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Can you reduce the risk of an infant developing eczema?

Tanya Wright BSc Honours MSc Allergy HCPC Registered Dietitian MBDA

Breastfeeding has many benefits for both the mother and infant and should always be recommended as the first choice of feed.

Eczema is a growing modern epidemic

The occurrence of eczema is greatest in young children, but the prevalence of allergic diseases worldwide is rising dramatically in both developed and developing countries. Eczema can occur from birth, an introduction to formula milk, or when weaning commences.

Its impact extends to the whole family

Apart from the visible effects on the baby, eczema can also affect the whole family, socially, psychologically, and financially. Sleep deprivation, low self-esteem, exclusion from activities, along with inconvenient time schedules for treatments, are often the reality faced by these families.

What are the options for feeding infants?

Breastfeeding is best for babies and should always be recommended as the first choice of feed. If exclusive breastfeeding is not possible however, reducing the impact of allergy (including eczema) in bottle-fed infants has been a major focus of research. The independent prospective GINI study, for example, enrolled over 2000 infants. It found that certain formulas containing hydrolysed proteins reduced the risk of eczema by over 50% in babies with a family history of the condition (those with at least one parent or sibling with allergy).

What the guidelines recommend

Not all hydrolysed formulas have been found to reduce the risk of developing eczema. Therefore clinical guidelines, such as the European Academy for Allergy and Clinical Immunology (EAACI), suggest choosing a formula that has been clinically proven.

Important

SMA H.A. Infant Milk should NOT be used if a baby has already been diagnosed with allergy to cows’ milk proteins or is suspected of already having an allergy to cows’ milk protein. SMA H.A. Infant Milk should be used as the first formula feed, before babies have been exposed to intact cows’ milk proteins.

New SMA H.A. Infant Milk - designed to specifically reduce the risk of developing allergy (e.g. eczema) to cows’ milk proteins.

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- Use from first formula feed
- Omega 3 and 6 LCPS
- Easy to digest

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6. EAACI Food Allergy and Anaphylaxis Guidelines 2013.
Developing as professionals

Taking on additional training and professional development can seem like a daunting and time-consuming prospect, but keeping on top of your skills and knowledge need not be a chore - and will reap benefits in the long run.

In this dynamic world of ours, we see rapid changes and developments on a daily basis. The question is how do we manage to cope with it and hopefully get on top of it?

In terms of our working lives as professionals, the importance of continuing professional development (CPD) makes a very big impact as it has been shown to be one of the tools that helps us to stay on top of things. It enhances and boosts self-confidence and is the right step in moving forward with development.

You may ask what CPD is, and why it is relevant to you. Simply put, CPD is a process by which busy professionals like us maintain and improve standards of practice. This is through the development of knowledge, skills, attitudes and behaviour that will not only improve, but also advance, the practice of healthcare.

Some of us may cry out that we have no time or resources to take on more work and make time for training.

However, there are always ways to get through this dilemma. You can plan or adopt a flexible structured approach for your development in accordance to your needs at your own pace. As a professional, you have the responsibility to keep your skills and knowledge up-to-date. Structuring your development helps you to be accountable for your experience, offering you opportunities to achieve career objectives.

CPD covers a wide spectrum of learning experience. Professional development is continuous, driven by the learning needs and development of the individual. It is evaluative rather than descriptive of what has taken place. and it is an essential component of professional and personal life. It is never an optional extra. It provides new perspective, adds to your confidence and further improves your interpersonal skills outside work.

The most effective personal development is the kind that flows from the experience and challenges that you encounter and overcome in your everyday role in life.

You may ask whether learning outside work counts towards your CPD. I would say yes, as anything that you can show you use to overcome challenges in your role is continuing professional development. Professional development includes all types of facilitated learning opportunities ranging from formal to informal learning opportunities.

So why not take every opportunity to harness every available resource to add to your repertoire of skills, knowledge and behaviour to better yourself and your community?

Unite in Health is embarking on running regional events on CPD this year so why not take this opportunity to find out more about CPD, its relevance to you, and how you can advance your practice. Also for those looking at revalidation, this will be an added benefit in getting you there.

Ethel Rodrigues
Professional Officer, Unite/CPHVA
E: ethel.rodrigues@unitetheunion.org
A new system to help doctors and nurses spot children suffering from abuse and neglect has gone live. Homerton University Hospital NHS Foundation Trust and Lancashire Teaching Hospitals Trust are the first hospitals in the country to use the new Child Protection - Information Sharing (CP-IS) system designed to help avoid tragic cases such as Baby P being repeated.

The system will now be rolled out across the country, connecting emergency departments, out of hours GPs, walk-in centres and local authorities through a national system that will alert clinical staff to those at risk of abuse or neglect.

Under the new system, when a child attends one of these care settings, a flag will appear on the child's record if they are subject to a child protection plan or are being cared for by a local authority.

Doctors and nurses will be able to see whether such children have frequently attended emergency departments or urgent care centres over a period of time, which can also be an indication of neglect or abuse. NHS workers are often the first people to see victims of abuse and neglect. However, previously child protection information was not automatically shared, and medical staff and social services were unable to see if a child had made multiple emergency department visits.

This system will bring information into one place for clinicians to access and allow NHS staff to see the bigger picture and alert children's social services if they believe a child is at risk.

Only NHS staff involved with the care of the child will have access to the information, which is non-clinical. It will be accessed via a secure electronic system and robust rules about who has permission to view the information are in place.

The system is now linking Homerton University Hospital NHS Foundation Trust, Lancashire Teaching Hospitals NHS Foundation Trust, Lancashire County Council and Tower Hamlets Council. All of England will be connected by 2018.

Health Minister, Dr Dan Poulter, who launched the new system said: 'As a practising NHS doctor, I understand the importance of health and care professionals working together and sharing the right information to stop tragedies like Baby P being repeated. This new child protection information sharing system will help to stop children at risk of abuse slipping through the net with tragic consequences.

'Where a child is at risk of abuse, frontline NHS staff in accident and emergency departments and other urgent care settings, will now, for the first time, have access to this easy to use system, helping them to step in and take action to protect vulnerable and neglected children.'

Hilary Garratt, Director of Nursing, Nurse Commissioning and Health Improvement at NHS England and sponsor for the Child Protection-Information Sharing system, said: ‘Too often we have seen cases where children at risk of abuse have slipped through the net with tragic consequences. This system is a real step forward and will put vital information in the hands of healthcare professionals that can make a difference and help protect these vulnerable children.'
Tax credits ‘more effective’ at reducing health inequalities

A STUDY BY RESEARCHERS AT THE Scottish Public Health Observatory (ScotPHO) has shown the extent to which regulatory and tax interventions that redistribute income are more effective at reducing health inequalities than interventions focused on individual health behaviours.

The study, ‘Informing investment to reduce health inequalities in Scotland’, developed an interactive tool to model the impact of 11 interventions over a period of 20 years on health and health inequalities ranging from changes to income and employment to investment in smoking cessation, alcohol brief interventions and weight management services.

Results showed interventions have markedly different effects on health and health inequalities. The most effective interventions were regulatory and tax options to redistribute income. Interventions focussed on individuals changing their own behaviours were much less likely to impact on inequalities, even when targeted at those in the most deprived communities.

Dr Gerry McCartney, Head of the Public Health Observatory (PHO) at NHS Health Scotland, said: ‘Reducing health inequalities has been identified as a priority issue for the Scottish Government. Our results show many interventions may improve population health, although they won’t necessarily help to reduce health inequalities.

‘While regulatory and tax options may not seem to be directly health-related, they will save lives, and ultimately save the NHS precious money and resources. Interventions that redistribute income, such as increasing the standard rate of income tax or implementation of a living wage, are among the most effective interventions for reducing inequalities and improving health. These results are consistent with previous evidence that interventions that tackle inequalities in the socio-economic environment and regulatory interventions are more likely to reduce health inequalities. In contrast, interventions focused on the individual were less effective, but could be useful in mitigating against increases in health inequalities in some areas.

‘Uniquely, we are now able to quantify and compare the impact on health and inequalities across a range of interventions.

Future research in this area will consider an even broader range of interventions and outcomes.’

Jamie Hepburn, Minister for Sport, Health Improvement and Mental Health, said: ‘This government is clear health inequalities cannot be solved with health solutions alone. They are rooted in poverty and income inequality. In the face of the UK government’s welfare cuts, we are using all the powers at our disposal and working with all of our partners to tackle poverty and inequality and help people into work.

‘We’re absolutely committed to increasing the number of people receiving the living wage. This report concludes the living wage can play a significant part in reducing health inequalities. As part of the Programme for Government, we will provide funding to more than double the number of organisations signed up to the Living Wage Accreditation Scheme.

‘These measures, and others, coupled with decisive and targeted action on alcohol, smoking, active living and mental health, all play their part in tackling health inequalities and delivering a more just society.’

Newborn screening programme expanded

NEWBORN BABIES IN ENGLAND AND WALES ARE BEING screened for a greater number of genetic conditions from January 2015, following a successful year-long pilot that identified an additional 20 babies born with rare genetic conditions.

The heel-prick test, performed on babies between five and eight days old, previously tested for five conditions including sickle cell disease, cystic fibrosis and congenital hypothyroidism (CHT).

The new test will also check for maple syrup urine disease, homocystinuria, glutaric acidemia type 1 and isovaleric acidemia. These inherited diseases disrupt the body’s ability to break down amino acids, leading to a potentially dangerous build-up of proteins if not identified early.

It is hoped the screening programme will reduce the number of babies seriously affected by the effects of rare conditions and improve survival and outcomes.

Public Health Minister for England, Jane Ellison, said: ‘This is really welcome news. Expanding the screening has the potential to make a huge difference to the lives of babies born with rare genetic disorders. Detecting the disorders early can help prevent babies being severely disabled or even dying, which is absolutely vital for the families affected.’
Parents advised to swap sugary snacks

A study has found that implementing simple swaps in children’s diets can dramatically cut their intake of sugar. Guidelines by Public Health England (PHE), as part of the government’s Change4Life campaign, outline a series of ways parents can swap sugary snacks and treats for healthier alternatives. These include substitutions such as yoghurt instead of ice cream as a dessert, or sugar-free drinks instead of sugary ones.

As part of the study, a sample of 50 families followed the PHE guidelines for a month and as a result, each family reduced their sugar intake by an average of 40 per cent – the equivalent of 49 sugar cubes.

Current guidelines recommend that a person’s calorie intake should be made up of no more than 10 per cent sugar, yet it is estimated, on average, children aged 4-10 are consuming up to 50 per cent more.

Almost a third of this extra sugar comes from drinks such as fizzy pop and fruit juice, while sugary snacks such as sweets, cake, biscuits and chocolate represent a further third.

Professor Kevin Fenton, National Director of Health and Wellbeing at PHE, said: ‘Reducing sugar intake is important for the health of our children both now and in the future. We are all eating too much sugar and the impact this has on our health is evident. ’This campaign is about taking small steps to address this. We know from past campaigns that making simple swaps works and makes a real difference. ’This year we wanted to be even more single minded in our approach, which is why we are focusing on sugar alone. ’The family challenge highlights that simple swaps could lead to big changes if sustained over time.”

Fran Rowland, 32, from London, one of the parents who took part in the pilot along with her three children said: ‘I’m really glad we took part. The kids have really stuck to the swaps and still don’t have sugar that often. ‘Now after school they ask for cucumber and hummus rather than sweets.’

A full report of the study and a list of the suggested substitutions are available on the PHE website.

Community services face patient scrutiny

The Friends and Family Test (FFT) is being rolled out to community and mental health services from January 2015, allowing patients to give feedback on their experiences of treatment and care.

The test, which is already operating in hospitals and was rolled out in GP practices at the end of 2014, asks patients if they would recommend the services to their friends and family. Respondents are asked to grade their experience on a six-point scale, ranging from ‘extremely likely’ to ‘extremely unlikely’ to recommend.

Health visiting and children’s services are among those on which patients will now be invited to give their feedback.

The results from the FFT are published monthly on the NHS England and NHS Choices websites, and are available to the public.

Tim Kelsey, NHS England’s Director for Patients and Information, said: ‘The NHS is at its best when it listens hardest to patients and service users. We are committed to an authentic culture of patient and public participation – to be open and transparent – and give patients, citizens and the care professionals who serve them the information they need to continuously improve local services. ‘The FFT was launched last year in A&E departments and inpatient wards in hospitals, and the real-time patient feedback it has generated is driving genuine improvements in care delivery. This improvement will only continue with the expansion of FFT into mental and community services, as well as GP practices.’

The FFT is intended to allow services to respond quickly to patient concerns, but has faced a backlash from those who feel it lacks a solid evidence base and is confusing for patients.
Drowning is a ‘serious and neglected’ public health threat

THE WORLD HEALTH ORGANISATION (WHO) HAS identified drowning as one of 10 leading causes of death for children and young people in a report into its global prevalence.

Children under five are ‘disproportionately’ at risk of drowning, with males twice as likely to die by drowning than females.

The process of drowning is difficult to reverse once it has begun, and survival is dependent on two main factors – namely how quickly the casualty is removed from the water, and the speed at which resuscitation is received.

It is therefore vital to ensure prevention of drowning by making sure both children and parents are aware of the risks associated with water, and how to aid those that get into difficulty.

The report recommends public awareness should be directed at specific risk factors, such as ensuring adult supervision of young children or reducing exposure to water hazards.

WHO describe drowning as a ‘serious and neglected public health threat’ in the report with ‘no broad prevention efforts’ in place to protect those at risk.

According to statistics from the National Water Safety Forum, there were 335 deaths from drowning in the UK in 2013, 46 of which were of those aged under 19. The majority of accidents in this age group occurred on rivers and coastal areas. Swimming pools, baths and jacuzzis were also responsible for child deaths.

Health visitors urged to discuss sleep patterns

THE IMPORTANCE OF NURSES AND health visitors in reassuring parents about what constitutes a ‘normal’ sleep pattern has been reinforced by a study by researchers in the US.

While parents are typically prepared for their baby’s sleep pattern to be disrupted during the first six months of life, authors found disruption beyond this time often worries parents.

The research highlighted four main areas that cause concern to both parents and healthcare professionals. Many are confused or worried about what a ‘normal’ sleep pattern is, whether nocturnal waking is a cause for concern, the role of parents in helping soothe a baby back to sleep, and whether it is advisable to use sleep training.

The study, published in the Journal of the American Association of Nurse Practitioners, also noted that although training may help to establish a regular sleep pattern, the process and methods used in sleep training are not always in the best interests of families.

Authors concluded nurse practitioners are well placed to offer advice and guidance on infant sleep pattern norms, current knowledge about night-time waking and parental presence, and approaches to altering infant sleep patterns.

Combining evidence-based advice with individual preferences and cultural practices would reassure parents to feel confident in their decisions and behaviour.
Child hospital admissions for self-harm at five-year high

THE NUMBER OF CHILDREN BEING ADMITTED to hospital in England as a result of self-harm is at its highest level in five years, according to statistics from the Health and Social Care Information Centre (HSCIC).

Admissions among girls aged 10-14 rose from just over 4,000 to nearly 6,000 in 2013/14. While admissions among boys remain much lower than those among girls, there was still an increase of 45 per cent to 659 during the same period.

‘Youth mental health charity Young Minds defines self-harm in children as being ‘when a young person chooses to inflict pain on themselves in some way’.

A World Health Organisation (WHO) survey, due to be released in 2015, is also expected to show the number of teenagers who have self-harmed has tripled over the last decade. The survey was composed of around 6,000 participants and reveals many children are self-harming more than once a month.

Research suggests children are more likely to engage in self-harm if they have witnessed it elsewhere, and that easy accessibility of materials depicting these acts is thought to be one possible reason for this rise.

Self-harm can take many forms including cutting, burning, biting, hair pulling, intentional overdosing and poisoning.
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#Unite_CPHVA #CPHVATT

#CPHVAtt: 0-19 obesity

IN DECEMBER 2014 CPHVA hosted a Twitter chat on childhood obesity and what can be done to help reverse it.

@bernie_hughes
Spend some money on advertising health promotion message. Fit for life great but ads not prolonged enough

@myka_yallop
we run a joy of foods cooking course and that really helps the families get involved :)

@Richard_Cotton1
I have to be careful, but it might help not to assume parent reads English. High ethnic pop, high level of obesity.

@mjfanner
restrict shops that sell unhealthy snacks from being open 24/7 or be closed during school lunch breaks.

@SarahHughesF
shocking figures, 19.1% year 6 are obese, with this increasing, we certainly need a plan to tackle this

@surreynourish
seeing all of large caseload at 12 wks would take HV resources away from those who need

Twitter Tuesdays take place every week from 7–8pm. To join in, use the hashtag #CPHVAtt

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Unite CPHVA briefings

Unite CPHVA briefings are produced by the professional officer team to give members access to the most up-to-date information on issues relating to practice. The following summaries are three of the newest briefings that can be read in more detail at your convenience.

**Female genital mutilation**

Female genital mutilation is a violation of human rights of girls and women. It involves a procedure that intentionally alters or causes injury to the female genitalia for non-medical reasons. The Unite position on this is that it is criminal, inhumane and a cruel act against children who are entrusted into the care of their families. This briefing is designed to help practitioners in their everyday practice. It describes the issues and the concerns you need to consider in practice and how Unite has worked to address this and support your work by lobbying for a positive change in how it is dealt with.

**Update on revalidation**

Revalidation is the new mandatory process by which registered nurses and midwives will be required to demonstrate to the NMC on a regular basis that they continue to adhere to the values and principles in the Code and remain fit to practise. It seeks to promote greater professionalism amongst nurses and midwives, improve the quality of care that patients receive and enhance public protection.

**The new birth visit**

This professional briefing aims to help to raise the profile of the health visitor and health visiting services as the service with the required knowledge and skills to undertake the new birth assessment visit safely and competently. It should also raise the profile and importance of the new birth visit when seeking to engage and develop ongoing relationships with clients (mothers and families) and help to influence and contribute to the thinking of managers and commissioners when they are seeking to make decisions about changing service design and delivery options.

For the full archive, please visit www.unitetheunion.com/cpha

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**#AdaywithDave: Karen Heggs**

**MY DAY WITH DAVE CAME AS I APPROACHED** the end of my SCPHN HV course at a time when I am thinking forward to my new career. It has been a challenging but inspiring year for me, and I was delighted to be given the opportunity to go to London and see the work of Dave Munday and the staff at CPHVA first hand.

When Dave asked me what I wanted to gain from the day, I felt quite clear that I wanted to consolidate my appreciation of the concept of the HV as a leader. Throughout my course I have spent a great deal of time considering how I could lead others as a HV. I had never considered myself a leader as I always believed that to lead, you need to be in a position of authority. Yet, I have come to appreciate that as a HV I am in an excellent position to lead others both locally and regionally – the clients I work with, my colleagues and other professionals.

My day with Dave allowed me to appreciate the role of the HV as a leader at a national level and the influence we can have on the policies that affect our role and the clients who we support. Our plan for the day was changed at the last minute when a meeting had to be cancelled, however, we were able to arrange a face-to-face meeting with Tim Horton (senior advisor to Ed Milliband) and, while at Parliament, we were also able to grab a quick opportunistic meeting with Andrew Gwynne MP. These meetings came about only by chance, and I was able to observe how Dave generated opportunities and seized chances as they arose to generate purposeful and productive meetings, and it was great to feel a part of this.

It was rewarding and insightful to consider that what I said may have been influential in some way – raising their awareness of the role of CPHVA and the important role of the HV and the positive influences that we make.

Tim asked for our opinion on perinatal mental health issues and was keen to hear about our experiences as HV’s in dealing with these issues. I felt we were able to make our voice heard, Dave and I both reflected that we felt he genuinely wanted to hear what we had to say, our ideas and suggestions, and we stipulated very clearly how we believed we wanted him to take our suggestions forward. Both meetings were opportunistic, but very fruitful, and we came away feeling we had made an impact.

My day with Dave consolidated my belief that as a HV I can make a difference and influence others as a leader, no matter how small this difference or influence may be; I believe that small differences can lead to big changes. As a HV I will move forward and take up the challenge of working as a leader for my clients, by working not just to support and guide them, but also to be proactive in influencing the policies that will affect them. My day with Dave was an excellent learning opportunity and provided me with an instilled enthusiasm and drive to make a difference, to seize any chance and generate opportunities.
BREASTFEEDING IS BEST FOR BABIES

Less is more: the UK’s first reduced protein infant milk, now with alpha-lactalbumin

High protein intake in the first two years of life has been linked with an increased long term risk of being overweight or obese. Our new infant milk with 1.89g protein/100kcal, and added alpha-lactalbumin, is the first formula in the UK to contain less than 2g protein/100kcal (Figure 1).

The BeMIM (Belgrade-Munich Infant Milk) study

Aim: to prove the safety and suitability of the reduced protein formula for healthy term babies aged 0-4 months and non-inferiority compared to a standard formula.

Results

- Adequate growth: no significant difference in weight gain between formula groups
- Good tolerance and acceptance: both formulas were well accepted and tolerated. No differences in stool consistency and colour, colic, flatulence, regurgitation or vomiting
- Protein intakes closer to that of breastfed babies for those on the reduced protein formula (Figure 2)
- Positive influence on satiety: no compensatory increases in formula intake for babies on the reduced protein formula. In fact, these babies consumed significantly less energy at 90 days and 120 days of age compared to the control-fed group. This was explained by lower meal frequency, which might indicate higher satiety
- Improved energetic efficiency: Weight gain per 100kcal and length gain per 100kcal were significantly higher in the 4th month for the intervention group compared with the control group. This could be due to the improved protein quality of the intervention formula.

To find out more, visit hipp4hcps.co.uk

References:

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Association

Annual reflection

THE PAST YEAR HAS BEEN challenging, inspiring and a time for meeting new friends and greeting old ones. I am very delighted we have a new President, Polly Toynbee, who no doubt many of you met at CPHVA’s annual conference in Birmingham 2014, have read her piece in the journal or are fortunate like me to have spent a day with her showing her what health visiting is all about on the frontline.

Last year, due to many commitments both as national chair, local staff side representative and branch secretary, I haven’t travelled and met as many members as I would have liked to have done, so please send your invites in for 2015. I did, however, have the chance to attend my first CPHAwards ceremony, a student question time event in Durham, a regional workshop on record keeping in Leeds, took part in a Unite in Health Thinking Time workshop, got involved in the Jarrow March and the NHS leverage campaign to name a few.

All I hope is that you all managed to do at least one of these things (if not why not?) Most of them are free events that help to maintain your competencies, meet your knowledge and skills outline and help with revalidation, but more importantly, make you a better practitioner delivering a better service to our children, families and patients.

If it is down to release, lack of staff, high caseloads, the health visitor implementation plan targets not being met then the professional officers and executive team need to be made aware as they have regular meetings with various national departments across the United Kingdom.

The activities I refer to are all part of the role of this professional organisation – one I am very passionate about and one I have been involved in now for over 30 years BUT you too can be involved even if it’s just at your desk. Email topics for #UiHTT, articles for the journal and topics for regional workshops, attend your branch meeting and tell your representatives what you need! No branch meeting? Then email me Carolyn.taylor@stft.nhs.uk

Each Unite region bar Wales and the North West has a regional representative who sits on the CPHA executive and my thanks go out to them for their support and work that they have voluntarily completed this year. The CPHA is very much like the NHS in that it is built by members for members and will only be around as long as we have members who want it, will fight for it and have members who tell them what they need! 2015 is going to be the most important year for all NHS workers so make sure you keep in touch, get involved and take part in the fight to SAVE OUR NHS.

Here are some 2014 reflections from a selection of CPHA executive members...

Carolyn Taylor, chair CPHA executive committee, chair health visitor OPC, chair North East OPC

Yearly report: South East region

The South East region OPC meets four times a year. In previous years, the professional forum (now the OPC) has been very well supported by most trusts within the region. Unfortunately this year has seen reduced members attending, mostly due to increased workload demands and members being unable to be released from work.

Some Unite branches appear to be functioning well while others appear not to be supported following the change from CPHVA centres into the Unite branches. The concerns members continue to raise are possibly mirrored across the country: service redesign, increased workloads, community staff nurse redundancies, low staff morale, mileage rates and epay.

Reps have been proactive in recruiting members in one area of the region by holding days whereby ‘Unite comes to meet you’. There have been breakfast, lunch and teatime meetings, with food provided, at various venues around the trust offering quizzes and information on the benefits of being a Unite member. Unite has also been invited, and attended, health visitor and school nurse celebration days – this has all resulted in raising the profile of Unite and the recruitment of new members.

As the regional chair I have also attended the national OPC meetings and CPHVA executive committee meetings, and as CPHVA executive member I have attended meetings in London four times a year where along with the representative from Northern Ireland, I have been the executive link for professional activity regarding revalidation.

As the South East is a large geographical region, looking to the future, we need to embrace technology for the possibility of virtual meetings to fit in with busy lifestyles and work commitments as well as looking at different venues and times for meetings.

The aim for the future is to increase the engagement of professionals at a regional level, and to re-engage members from the trusts and branches who have not recently been represented. I welcome contact from members in the South East region who would like more information.

Margaret Warner, chair South East region OPC, South East representative on national OPC and CPHA executive member
Yearly report: school nursing

As the school nurse Organising Professional Committee (OPC) representative, I contribute to the professional work of the CPHVA. As chair of the group, I attend the quarterly meetings and work with the other chairs to discuss, debate, develop and complete the executive work plan of 2013-14. There are still many vacancies for school nursing regional representatives to help take the work plan forward – the more of you who come forward, the stronger we will be.

Over the past year, I have represented the CPHVA and school nursing in the following activities:

- executive committee meetings – highlighting issues of interest to those working with school aged children; developing the executive work plan for 2013-14;
- OPC chairs meeting – to feed back to the Unite head of health, along with other chairs from the health sector, the areas affecting or preventing the smooth running of the committee;
- conference planning meetings to inform the 2014 professional conference schedule;
- Department of Health school nursing event, where I staffed the CPHVA information stall;
- National Children’s Bureau – Health Policy Influencing Group: discussion on the pre-consultation for the document Supporting pupils at school with medical conditions;
- liaising with the professional officers to plan agendas, discuss school nurse specific publications that need updating;
- participating in policy/document consultations on topics of interest;
- nominating colleagues for the CPHVA Awards;
- Community Practitioner journal – I now sit on the editorial board and have attended my first meeting in October 2014;
- CPHVA regional update conference on record keeping and duty of care. It was a great opportunity for CPD and networking and I look forward to further events in the near future;
- I was fortunate to be nominated and attend the royal garden party at Buckingham Palace last year on behalf of the CPHVA, which was very enjoyable.

The 1-2-1 school nurse campaign continues with regular updates, advice and action plans available on the website and through the professional journal. School nursing staff are encouraged to be more proactive and get involved locally and nationally to keep up the momentum as well as encouraged to participate in the forums to keep this work going so please keep in touch by email or teleconference if you are unable to attend meetings.

Lucretia Baptiste, chair, school nurse national OPC and London/Eastern region

Yearly report: West Midlands

West Midlands region has the common issues of poor member engagement and motivation. We have had an interesting year supporting branchless members and seeking support from Unite to get health branches up and running in order to enable the region to run as per the rules and focus on professional issues. Despite this, we have new interested members, we have a delegate to the health visitor OPC and our community nursery nurse continues to take part in the CNN OPC. Unfortunately, we have been unable to recruit a school nurse delegate. Our issues remain meeting places and lack of communication, however, there has been progress and this is encouraging.

Next steps for 2015

- to communicate to branches asking for support for their meetings;
- a new, safer accessible meeting venue;
- recruit a school nurse delegate to the OPC;
- stimulate activity and strengthen networks;
- increase social media activity - (80 Facebook friends and counting at time of report).

Su Lowe, chair West Midlands region OPC

Yearly report: Northern Ireland

- Workforce planning – a commitment to recruit more health visitors and increase numbers in 2014/15 and 2015/16;
- the family nurse partnership scheme is now being rolled out to all trusts in Northern Ireland;
- a drive to achieve 100% antenatal contact for all women as a priority;
- the number of school nurses will also be increased as supported by Unite;
- caseload weighting continues to remain as an important feature in defining the specialist community public health nurse’s role and workload, and in identifying pressures in workload and outcomes;
- I received positive feedback from members who attended the CPHVA conference and I would encourage others to attend in 2015.

Janet Taylor, acting vice chair of the CPHVA executive committee
**New resources**

**Tips for a healthy start**
Child obesity prevention charity Health, Exercise and Nutrition for the Really Young (HENRY) has launched a series of tips aimed at helping to reduce childhood obesity by establishing lifelong healthy habits. Along with dietary and lifestyle advice, it also helps reassure parents that it is never too late to start taking steps towards a healthier way of living. The full list of 15 tips is available at: www.henry.org.uk/tips-healthy-start

**Safer internet use**
The theme for this year’s global Safer Internet Day [SID], taking place on 10 February, is ‘let’s create a safer internet together.’ A number of materials, including an online television channel and educational packs for school-aged children, are available to help promote the message of safe internet use and to protect children from potential harm online. Tweet about the event using the hashtag #SID2015 or access UK-specific resources from: www.saferinternetday.org/web/united-kingdom/home

**Perinatal mental health**
An independent report commissioned by the Maternal Mental Health Alliance, a coalition of UK organisations committed to improving the mental health and wellbeing of women and their children in pregnancy and in the first postnatal year, has highlighted the high cost of perinatal anxiety and psychosis to society. The report, entitled ‘The costs of perinatal mental health problems’, is available for download at: www.centreformentalhealth.org.uk/pdfs/Costs_of_perinatal_mh.pdf

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**Coming to a place near you: Unite in Health regional events 2015**

**FOCUSBING ON**
Continuing professional development (CPD)
• What is CPD?
• Why your CPD is important?
• The requirements of regulatory bodies
• Planning your CPD
• Benefits of CPD
• CPD activities
• How to demonstrate your CPD evidence
• E-Portfolio
• KSF

**RAISING CONCERNS**
• What does raising concerns mean?
• Types of concerns
• Your duty to raise concerns
• How to raise concerns
• Your Employers duty to respond and investigate
• Examples of how to raise concerns formally
• Flow chart on raising concerns
• What happens next?
• Whistleblowing

Unite/CPHVA is a member of CPD Certification Service UK.

For CPD certification of Trainings, Workshops, Conferences, Learning and Education events, please email ethel.rodrigues@unitetheunion.org

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**Unite in Health Thinking Times**

We know how important it is to our members in the health sector that they have time to develop their skills and knowledge. We also know that with the current climate in the health sector, this has become more and more difficult to achieve. That’s why we’ve launched Unite in Health Thinking Times (#UIHTT).

UIHTT will cover topics that our members tell us are important. And to help with less time being available to be involved in training, we’ve developed it in a ‘webinar’ style. The modules are free to Unite Health Sector members and once you apply via the online form for a session, we’ll send you details of how to join in.

Sessions available in February 2015 are:

**Ethical interpreting in health care**
Presented by Prof. Alison Phipps, University of Glasgow, on 5 February 2015 at 3:30pm

**Talent for Care HEE Strategy on Bands 1 to 4**
Presented by Kirk Lower, Director of the Cambridgeshire and Peterborough, Norfolk and Suffolk Workforce Partnerships, Health Education East of England, on 12 February 2015 at 3:30pm

**NMC revalidation**
Presented by Jackie Smith, Chief Executive and Registrar at the Nursing and Midwifery Council, on 25 February 2015 at 3:30pm

To book your place please visit http://tinyurl.com/UIHTT
Sex is biologically determined from conception, but gender is a psychosocial construct determined by individuals’ experience of being male or female, being largely learned through environmental and social cues. What impact does this have on children and is gender a problem that needs to be addressed?

George F Winter, Independent Writer
All human eggs contain an X chromosome, so our sex rests on the outcome of a race for the egg between millions of spermatozoa, each of which has either an X or Y chromosome. If a spermatozoon with an X chromosome gets there first, the foetus will be XX and female; alternatively, an XY combination denotes a male.

According to Yanof (2000), children are able to ascribe a gender to themselves by the time they are around two or three years old. However, a child’s concept of gender is different from an adult’s. A girl can choose an anatomically correct doll as being like me, yet is unable to label the doll correctly according to its genitalia (Yanof, 2000). This suggests it is unnecessary for a child to understand the relationship between gender and genitals before identifying as a boy or a girl.

A further study by Zosul et al (2009) showed such self-identification depends on children between the ages of two and three years uncovering gender-related information. This was confirmed by LoBue and DeLoache (2011), who showed while toddlers are beginning to talk about gender and acquire gender-related knowledge, their colour preferences are also gender-based. The authors investigated almost 200 children aged between seven months and five years who were offered eight pairs of objects and asked to choose one. There was always a pink object in every pair. By the age of two years, pink objects were chosen more often by girls than boys, and by the age of 2.5 years, ‘… they had a significant preference for the colour pink over other colours.’ In contrast, boys increasingly avoided pink.

This is hardly surprising given the widespread parental and societal preference to dress infants in the gender-specific colours of blue for boys and pink for girls. An additional impetus towards the popular trend for selecting gender-specific clothing, toys and accessories could be the availability of prenatal testing, which allows parents to select gender-specific coloured products well in advance of birth. However, as LoBue and DeLoache point out, most studies of pre-school children have shown they actually prefer primary colours, such as red and blue, to secondary colours, such as pink or orange.

THE AGE OF CONSUMERISM

In Western societies it is clear the age of consumerism continues to exert a powerful influence on our lives, including young children, whose developing awareness of their gender is open to subtle (and not-so-subtle) manipulation by advertising. For example, in January 2014, Education Minister Elizabeth Truss warned the future careers of children could be adversely affected by gender-specific toys, with fewer girls wishing to study maths and science (Paton, 2014). She encouraged parents to buy Lego for their daughters to stimulate interest in engineering, and her comments came after retailer Marks & Spencer agreed to make the packaging of its toys gender neutral, following a campaign led by the organisation Let Toys Be Toys, set up in November 2012.

On its website (www.lettoysbetoys.org.uk) the group asks why children’s play should be limited by gender-specific products, and addresses the topic of marketing, arguing ‘directing consumers in this way is restricting children’s play’ and that ‘the real world has moved on. These gender stereotypes are tired and out-of-date’.

GENDER-SPECIFIC CLOTHING

A recent study by Halim et al (2014) of three- to six-year-old children from diverse ethnic and parental income backgrounds suggested children’s behaviour in relation to their appearance was both gender-related and inflexible, reflecting an early knowledge about gender identity. One finding was that girls exhibited greater gender appearance inflexibility than boys. The authors suggest one possible explanation: For girls, being a girl might mean looking like a girl. For boys, we speculate being a boy might largely mean something else, such as acting like a boy.

One might infer from this that ‘being a girl’ is defined mainly by appearance, but ‘being a boy’ is defined less by how a boy looks but by how he behaves.

One aspect of the relationship between gender-specific clothing and the developing child that has received increasing attention over recent years is the so-called ‘sexualisation’ of children. In 2010, Psychologist Dr Linda Papadopoulos was asked by the Home Secretary to conduct an independent review on the impact of the sexualisation of young girls on violence against women. In her report Papadopoulos (2010) noted ‘… that we could not talk about girls without acknowledging the concomitant impact on boys and the hyper-masculinised images and messages that surround them.’
In the UK, girls can now expect to reach puberty, defined as the development of breast buds, around their 10th birthday, and, on average, girls have developed more evident breasts by 11.6 years of age. This is around 18 months earlier than was the case two generations ago. However, it is worth pointing out studies of early-onset puberty have found links to body mass index, exposure to certain chemicals, stress, climate and light cycles, so it would be wrong to assume there is necessarily a causal relationship between early onset puberty and the sexualisation of children.

**EQUIPPING CHILDREN TO DEAL WITH GENDER STEREOTYPING**

A robust challenge to the findings of the Dr Papadopoulos report came from Professor Clarissa Smith (2010). She said, ‘I had no great hopes for Linda Papadopoulos’s Sexualisation of Young People Review and it didn’t disappoint.’ Professor Smith suggested Dr Papadopoulos presented ‘sexualisation’ in simplistic terms, ‘… as a singular object of concern and children as “incomplete” beings unable to resist the blandishments of the media designed to seduce them.’ Professor Smith further challenged the construction of the word ‘child’ as an ‘identity category’, ‘… whose entitlement is “innocence” and who must be protected by a range of disciplinary and institutional interventions.’

Professor Smith’s approach is typical of a view identified by Bailey (2011): ‘… that we should accept the world for what it is and navigate our way through it better’. The Dr Papadopoulos analysis, some would argue, risks infantilising adults by making them give children the tools to understand it and navigate their way through it better.

In a report carried out for the Department for Education, Bailey (2011) cited a UK survey in which 55 per cent of parents thought adult-style clothes for children in shops encourage children to act older than others might do, giving more credit to the discriminating abilities of children than others might do. ‘In the UK, girls can now expect to reach puberty, defined as the development of breast buds, around their 10th birthday, and, on average, girls have developed more evident breasts by 11.6 years of age.’

Might children be more aware of how gender-specific clothing and other products are influencing their development than adults give them credit for? There would be no advertising around if it didn’t work – so if advertising generates profits by promoting gender-specific clothing and products that risk ‘sexualising’ children, it is probable most companies’ CEOs will lose little sleep over the subject. While Professor Smith’s analysis gives more credit to the discriminating abilities of children than others might do, there is a strong argument that children should be entitled to a period of innocence during their development.

To what extent are those who undergo ‘gender-reassignment’ surgery transformed from male to female or vice versa? Feminist writer Germaine Greer (1974) points out in her review of a book written by Jan (formerly James) Morris, ‘Jan Morris is a man who has eaten a great many pills, artificial hormones and the crystallised essence of the urine of pregnant mares, a man who has had his penis cut off, but a man nevertheless.’ It may not be possible to change one’s sex, but to hope to acquire one gender at the (perhaps) partial expense of the other.

When it comes to psychologists identifying universal laws of human behaviour it all becomes a bit messy where gender is involved. Clearly, there is much research to be done in this important field; not only to support the healthy development of children but also to help ensure lessons can be learned and applied in the area of adult relationships, too.

**REFERENCES**


Championing children

Hilary Cass is the President of the Royal College of Paediatrics and Child Health (RCPH) and was awarded an OBE for her services to child health in the 2015 New Year honours list.

Originally trained as a paediatrician, Hilary Cass has turned her focus and attention to how multidisciplinary teams can work together to improve overall child health, earning herself an OBE in the process. She travels around the country meeting professionals, politicians and young people to collect ideas and campaign for better health outcomes for all children.

Q. What is your background and how has it helped you in your current role?
I’ve had a pretty varied background. Initially, of course, was my clinical role – first in general paediatrics and then paediatric neurodisability. But the roles that have helped me the most for my current post as President have been in education and management. My first major such role was as Director of Medical Education at Great Ormond Street. Then I had a lot of other education roles in London - eventually Head of the School of Paediatrics. The common factor from working in neurodisability and in education was a culture of working across different professions. There is almost nothing you can do for a child with a disability if you don’t have a strong partnership with every other discipline. Similarly, in education, there are many shared learning activities across professional groups.

The other key roles have been in management positions, leading major system change. Probably the biggest change was setting up the first ‘hospital at night’ model at Great Ormond Street, which involved getting everyone – nurses, doctors and managers – to buy into a completely different way of delivering out-of-hours care.

Q. Describe some of the activities that led you to receive your OBE
I have been very vocal in my belief that child health outcomes in the UK are not as good as they should be – calling for new ways of delivering care in ‘child health hubs’, training for GPs in child health, and fewer, more specialist centres of care. I am also passionate about multi-professional collaboration across the child health workforce, and the RCPCH has embarked on many joint initiatives with a range of allied health groups and other organisations. During the past few years, the college has run campaigns to reduce childhood mortality, raise awareness of vitamin D deficiency and tackle childhood obesity – and developed some pioneering resources such as the MindEd e-portal (www.minded.org.uk) to support all professionals in identifying the signs of mental ill health in children. We have also recently secured funding for an online child health resource for those working in child health, Paediatric Care Online, which is currently available in the US, to be developed in the UK.

Q. Can you describe a typical day at work?
No such thing. Every day is different - and I can also wake up in any part of the UK because I am often on the road visiting colleagues in other parts of the country. But on any one day I can be doing things as varied as chairing a meeting at the college, meeting the Health Minister, talking to...
members of our Youth Advisory Panel, giving 
talks to trainees, going to the launch of a new 
healthcare initiative, or having dinner with 
another college president – and between all 
that trying to write a clinical report on a patient 
that I saw earlier in the week... and of course, 
staying on top of emails.

Q. What is your work currently focused 
on? What are the priorities and 
particular challenges you are facing at 
the moment?

I am passionate about the need for multi-
disciplinary working in order to improve child 
health outcomes. We've got to make sure all 
healthcare professionals – across primary and 
secondary care – not only have the individual 
knowledge to ensure children get the best 
possible care and advice, but also the right mix 
of expertise and support from their colleagues 
across other disciplines. For the majority of 
children who fall ill, their first contact with a 
healthcare professional is with their GP. Children 
and young people make up over 25% of the 
typical GP's workload, with pre-school children 
typically visiting six times a year and school age 
children two to three times. Yet, fewer than half 
of GPs are given the opportunity to undertake a 
paediatric training placement during their training.

We're working closely with the Royal 
College of General Practitioners to push for 
extending GP training to include more focus on 
paediatrics, so that GPs are confident and well 
equipped to treat children outside the hospital 
setting. It's this idea of more accessible services 
in the community, not just in GP surgeries 
but also pharmacies, health centres and, as 
is currently about to be piloted in my own 
hospital trust in Lambeth and Southwark, child 
health hubs.

At the moment, the hospital is seen by 
many as the "happening place to be." Too often 
it's the default place for worried parents to go 
when their child falls sick, when actually the 
problem is much more easily and effectively 
dealt with outside the hospital. But of course 
that requires a change to the system and the 
ways in which clinicians work; currently the 
majority of paediatricians work in a hospital and 
GPs work in their surgeries. We need to take the 
good parts of our system and learn from the 
best in Europe, looking at how more care can 
be delivered in the community by a broader 
team of healthcare professionals – for example, 
with paediatricians, specialist nurses and others 
co-located with primary care teams outside 
hospitals. Within these health hubs you could 
have teenage drop-in clinics, health promotion 
and healthy eating advice, as well as the 
management of long-term illness, all delivered 
in an environment geared around the needs 
of children or young people. We hope that 
by piloting this kind of close collaboration we 
will be able to develop services that are more 
convenient for patients, cheaper and produce 
better care – meaning we really will be putting 
patients first.

Q. What do you feel has been your 
biggest achievement so far in post?

Raising the profile of children's healthcare 
needs with government and colleagues across 
the sector, and helping to get consensus on 
the inescapable fact that we have to do things 
fundamentally differently if we are going to 
improve our poor health outcomes for children.

Q. What has been the biggest challenge 
for you so far?

Trying to get some of my colleagues to 
recognise that paediatricians are just a small 
part of the solution to the problems with our 
healthcare system, and that we will have a 
much stronger voice by acting together across 
the children's healthcare workforce. The trainees 
and young consultants recognise this more 
than some of their more senior colleagues.

Q. Do you have a high level of job 
satisfaction?

Phenomenally so. I couldn't be more lucky in 
having always had interesting, varied roles that 
give me the chance to meet the most diverse 
and generally dedicated people in all walks of 
life.

Q. What do you think is needed for 
effective leadership in a children's 
health role?

Firstly, recognition of the need to listen to 
children and young people - they say it 
unvarnished and are straight up about what 
needs to change. And secondly, recognising 
that children's health is everyone's business. 
Anyone who thinks that any one professional 
group has all the answers - or the right to speak 
on behalf of children - should not be in a child 
health leadership role.

Q. What do you think should be the 
priorities for the government for 
children's health? Is a new approach 
needed?

Towards the end of last year we launched our 
Vision 2015 manifesto – which sets out the 
priorities we feel the next government must 
commit to in order to improve child health 
outcomes. It proposes a suite of measures to 
improve the state of child health, including a 
named health professional for children with 
long-term conditions, early help for children 
with mental health problems, training every 
general practitioner and general practice nurse 
in child mental and physical health, 20 mph 
zones for traffic in residential areas, restricting 
advertising that encourages unhealthy eating 
and stopping children having cheap access to 
alcohol.

The main focus of health and social care 
policy from successive governments has 
been on meeting the needs of an ageing 
population. Many of the big ticket policies 
– such as pension increases, winter fuel 
allowances and free TV licences – have made 
a welcome difference to many older people. 
We now want to see equal focus given to our 
younger population. Not only should this be 
done because it directly benefits children and 
young people, but also because it will improve 
the health of the nation as a whole. Healthy 
children are more likely to be healthy adults – 
and of course the reverse is also true.

Of course, there has been progress in some 
areas including the formation of the Children 
and Young People's Health Outcomes Forum 
and recent announcements on children and 
young people's mental health, but progress 
is slower than it should be. We want to see a 
public commitment from all political parties 
to give child health the attention it deserves.

Many of the big ticket policies have made a welcome 
difference to many older people. We now want to see equal 
focus given to our younger population.
Have you nominated a colleague for School Nurse of the Year? The CPHVA awards are next month and although it’s often a last minute rush (busy, busy people) we do get amazing nominations. We have sent congratulations to Sharon White who received an OBE in the New Year’s Honours list for services to school nursing. Is this going to be school nurses’ year? Planned commissions for SCPHN SN training at 340 are nearly double what they usually are, but we still need ten times that to make a difference.

HEALTH AND ATTAINMENT
Public Health England put out a briefing just before Christmas titled ‘The link between pupil health and wellbeing and attainment’ (PHE, 2014) aimed at head teachers, governors and staff in education settings. I would suppose most education staff are well aware of this link, but so many environmental factors are outside of their sphere of influence that there is nothing they can do about it.

The WHO health promoting schools (WHO, 2015), which I mentioned last month is a very good initiative for term-time days, and is recommended in this guidance, but can only have limited effect on the financial and social factors that lead to disadvantage.

The key points from the evidence are:
• pupils with better health and wellbeing are likely to achieve better academically;
• effective social and emotional competencies are associated with greater health and wellbeing and better achievement;
• the culture, ethos and environment of a school influences the health and wellbeing of pupils and their readiness to learn;
• a positive association exists between academic attainment and the physical activity levels of pupils.

Doesn’t this remind you of the ‘Every Child Matters’ programme? Anyway, what we have here is a short evidence-laden briefing, which you can usefully show to school governors and local authority commissioners to persuade them that embedding health systems and policies into the structure and function of the school organisation will ultimately improve education outcomes.

You should then remind them that school nurses should be leading the health agenda in schools.

BULLYING AND ONLINE SAFETY
You may have read the Action for Children report (Action for Children, 2015), which we placed on our Facebook page, that found 40 per cent of parents worry about their children’s mental health – more than any other health issue. Bullying, both overt and insidious, causes a lot of misery and many children don’t seek help early enough to prevent long-term emotional damage.

The NSPCC has launched a public education campaign called Share Aware to
help parents keep their children safe online. The campaign is aimed at parents and carers of children aged eight to 12 – the age at which they start doing more online – become more independent and use a greater range of devices. The campaign aims to give parents the tools to feel confident about discussing issues with their children, so please will you alert your schools to this so that they can send out information to parents.

**DISABILITY RIGHTS**

Following on from a survey (Children’s Commissioner, 2014) carried out by the Office of the Children’s Commissioner (England), we are working with the Council for Disabled Children and other stakeholders on rights for disabled children and young people. This report presents a snapshot of 34 disabled children and young people’s views and perceptions about the realisation of their rights as outlined in the United Nations (UN) Convention on the Rights of Persons with Disabilities (United Nations, 2006), and raises serious issues and presents solid evidence about the fulfilment of disabled children’s rights in England.

Article 12 of the UN Convention states: ‘Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child; the views of the child being given due weight in accordance with the age and maturity of the child.’

However, it is apparent many statutory services are not involving disabled children when planning and commissioning services. One spin-off from this work is that NHS England will develop a child friendly version of the NHS constitution (NHS England, 2013).

**FOOD FOR THOUGHT**

Finally, don’t forget we are members of the Children’s Food Campaign (Sustain, 2015) and so do sign up to their campaigns about getting rid of sweets at the supermarket checkout and taxing added sugar in soft drinks.

**REFERENCES**


Changing the health of future generations
The implications of new findings in early life science

In recent decades, there has been a rise in Non-Communicable Diseases (NCDs) such as obesity, cardiovascular disease and cancer. Latest scientific evidence shows us that environmental factors acting during early life (from conception until 2 years), influence the response of an individual to later exposures, and thus influence later health and disease risk.\(^1\)

New science suggests that intervention needs to happen earlier.\(^2\)

Lifelong health is predominantly determined by environmental influences.\(^4\)

- **Nutrition**: Dietary habits, nutrient intake, taste exposure
- **Lifestyle**: Sleep, physical exercise, smoking
- **Disease**: Infections, obesity
- **Others**: Pollution

Nutrition is well documented to be a major influencer of health in later life.\(^1\)

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The first 1,000 days, from conception until two years old, represents a unique window of opportunity to help determine an infant’s lifelong future health.\(^5,7\)

This is because during the first 1,000 days of an infant’s life their organs and body systems are rapidly growing, still very flexible and responsive to nutritional influence.\(^8\)

Healthcare professionals can make a difference to the lifelong health of babies in their care by raising parents’ awareness of the significant role that nutrition and other lifestyle factors can play to positively influence lifelong health outcomes.

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The importance of getting the right nutrition during pregnancy
The nutritional status of a woman before she conceives and during pregnancy will impact on the health and wellbeing of the infant in both the short- and long-term.

Maternal body weight, diet and lifestyle can impact the offspring’s health in both the short- and long-term.\(^3\) There is increasing evidence that a mother’s weight and nutritional status before, during and between pregnancies can impact her offspring’s health and risk of disease in later life.\(^5,8\). It is also likely that there are ‘critical windows’ in the baby’s development, during pregnancy and early life, where they are particularly sensitive to nutritional imbalance.\(^9\)
Pregnancy is a key opportunity for health professionals to encourage women to make dietary improvements, as they tend to be more motivated to change aspects of their diet and lifestyle during this time to do the best for their unborn child.

The myth of eating for two

As the fetus is completely dependent on its mother for its nutrient supply, the quality of the mother’s diet is extremely important during pregnancy and even before pregnancy to ensure adequate nutrient stores. Pregnant women do not need to ‘eat for two’. In fact, women do not need any extra energy during the first six months of pregnancy. Some additional energy is required during pregnancy to support the development of new tissue for the fetus and placenta, and for the growth of maternal tissues including breast and uterus. Some of this energy cost is met by a reduction in physical activity energy expenditure and therefore women only need around 200 kcal (837 kJ) extra per day during the last trimester of pregnancy.1,10

Dietary advice around pregnancy

A healthy, balanced diet is essential during pregnancy.11 All pregnant women should be advised to follow a healthy, varied diet based on the eatwell plate.1,2,12 Dietary recommendations for pregnant women are similar to those for other adults, with some important exceptions.12,13 Although a healthy diet will give pregnant women most of the vitamins and minerals they need, some are so important for babies’ development that women will need to supplement as well.11,14,15 Five key nutrients important in pregnancy are:

- **DHA (omega 3)** which contributes to the growing infant’s brain and visual development during pregnancy12,16
- **Folic Acid** which helps prevent neural tube defects17,18
- **Iodine** which contributes to pregnant women’s normal cognitive function19
- **Vitamin D** which contributes towards the maintenance of normal bones through normal calcium and phosphorus absorption20
- **Iron** which contributes to the normal function of the immune system and to normal blood formation11,22

Inspired by the Science of Early Life and the important role nutrition plays, nutrimum has created a unique range of products which will be available soon.

REFERENCES:
Health visitors’ accounts of the impacts of ‘Hall 4’ on their practice and profession: a qualitative study

INTRODUCTION
This paper explores the impacts of Hall 4 on health visiting practice and on the health visiting profession. It is now a decade since the publication of the fourth edition of Health for All Children (Hall and Elliman, 2003) (commonly known as Hall 4). The publication of Hall 4, and the recommendations to shift away from routine child health reviews to a more targeted service, galvanised an existing debate contributed to by academics, policy-makers and those in the health professions. The debate focuses on health visiting services and whether they should be provided universally to all families or targeted to some families based on assessment of need.

Studies exploring the implementation of Hall 4 have considered the impact of the change in policy in relation to targeting (Condon, 2011). Condon’s (2011) study highlights how the policy shift to a more overtly targeted service, paradoxically, increased the targeted work necessary due to problems escalating for families and the importance of relationships-based work being diminished within policy discourse.

Machin and colleagues’ (2012) study, carried out in the time period following Hall 4, provides insight into the changes in identity experienced by health visitors. Machin and colleagues (2012) highlight the importance of a coherent and consistent collective identity for health visitors. Maintaining a collective identity is central; they suggest, to enabling health visiting practice and performance (Machin et al, 2012). It can, however, be a site of conflict during times of uncertainty and change. Machin and colleagues’ (2012) exploration of the link between health visiting identity and practice underlines the importance of understanding how health visitors receive and respond to policy change.

THE STUDY AIM
The aim of the overall study was to explore the impacts of Hall 4 on health visiting and families. Lipsky (1980, 2010) has argued that ‘street-level bureaucrats’ play a crucial role in implementing policy as their practices at local level shape how users experience it. It was health visitors whose practices were the focus of the policy recommendations of Hall 4. Hence, the production and analysis of health visitors’ own accounts is central to understanding the impact of policy change on health visiting.

METHOD
A qualitative approach was taken in the study. Qualitative methods allow for the study of social phenomena (Silverman, 2006:43). Hence, qualitative methods were chosen in order to capture how health visiting practices had been shaped by the implementation of Hall 4. The study was carried out in one NHS locality which...
had a broad socio-economic diversity. The study received ethical approval from NHS and University ethics committees. The study started in 2006 and the analysis was completed in 2012.

**DATA COLLECTION**

Discussions with policy-makers and practitioners working in the early years, nationally and locally, scoped the context for the study. Permission to discuss the study with health visitors was sought from health visitor managers in the study site.

Health visitors were provided with study information through education events and team meetings. Volunteer health visitors were asked to complete a contact form which was returned to the researcher who telephoned the health visitors to discuss the study further, respond to questions and, if the health visitor agreed, to arrange an interview.

Sixteen health visitors took part in the study. The health visitors had between 8 and 30 years of experience working as health visitors. Demographic information was collected to ensure socio-economic diversity within the sample. A topic guide was used to provide structure to the interviews while allowing flexibility to explore issues relating to Hall 4 raised by the health visitors. Key topics explored in the interviews were informed by the research aim, a review of policy and literature, and fieldwork. Health visitors were asked in interviews to describe a ‘typical’ day or week before being asked about Hall 4 in relation to benefits and challenges for health visiting, and impacts on families. Each interview took 45 minutes to an hour. Interviews were conducted face-to-face at the office-base of the health visitor. The interviews were carried out between 2007 and 2008. All of the interviews were transcribed verbatim.

**DATA ANALYSIS**

Demonstrating the process from the analysis of data within transcripts to the identification of themes and presentation of findings that describe a social phenomenon is important in social research to illustrate rigour and validity (Fereday and Muir-Cochrane, 2006).

In this study thematic and narrative techniques were drawn upon to guide the analysis of the data (Reissman, 1993). Thematic analysis is a form of pattern recognition within the data, where emerging themes become the categories for analysis (Fereday and Muir-Cochrane, 2006:62). Transcripts were read and re-read to identify broad themes across the data-set.

NVivo, a qualitative data analysis computer software package, was used in the initial stages of analysis to assist with the coding of the data and the identification of themes.

Over-arching themes of the study were: impacts of Hall 4 on health visiting practice and the health visiting profession; shifts in health visiting practice; mothering and vulnerability; health visiting, risk discourse and vulnerability. Narrative techniques were then used to explore particular aspects of the health visitors’ accounts which were not amenable to thematic analysis. Polkinghorne (1995) suggests that narrative can take a number of forms. He suggests ‘narrative as story’ is particularly suited as the linguistic form in which human experience as lived can be expressed (Polkinghorne 1995:6).

In the latter stages of analysis the following processes were used: noting, fragmenting, employment, thinking and writing about the data analysis. It was through writing about the data analysis and using social theory that an understanding of its gestalt was developed (Holloway and Jefferson 2000:68). The combination of thematic and narrative techniques enabled a grounded analysis of the health visitors’ accounts.

**FINDINGS**

In this section I explore findings from the study relating to the impact of Hall 4 on health visiting practice and on the health visiting profession.

I explore health visitors’ concerns about the impact of Hall 4 on health visiting expertise and tensions which health visitors expressed about the increased focus on child protection work shaping practice. I then consider the impact of Hall 4 on the morale of the health visiting profession.

**THE IMPACTS OF ‘HALL 4’ ON HEALTH VISITING PRACTICE**

The health visitors talked in their accounts about Hall 4 as a policy change which had been imposed on their practice. The majority felt that consultation that had taken place had been in order to implement changes to practice and had not been to draw on their experience of working directly with children and families to inform the development of policy.

Hall 3 … said one thing, and then it almost appears to be a complete u-turn in thinking made Hall 4, and it was just taken on board and introduced. … did nobody say, wow, that is a big change, should we maybe just check that this is the right thing to do? … whilst there were consultations … I didn’t really feel that any issues raised were really taken into account. I kind of got the impression it was a done deal. (HV10)

All of the health visitors interviewed expressed doubts about changes to their practice following Hall 4. The main emphasis in health visitors’ accounts around changing practice related to concerns about the reduction in the number of child health reviews and the consequent diminished opportunities to have contact with all children and families.

CK: … how do you feel about your role since Hall 4 has been implemented? …

HV4: Well, it has changed dramatically. … we are now not providing a service which I think was extremely valuable, and by that I mean the routine development assessments. (HV4)

… we are starting to notice from our nursery colleagues that since Hall 4 … there seems to be a steady rise in the number of language problems … within nurseries. (HV1)

Health visitors expressed concerns that changes to their practice would impact on opportunities for health visitors to develop and sustain health visiting expertise. The focus of this expertise was around child health development, which, the health visitors’ accounts suggested, they interpreted broadly in terms of necessary support and advice to enable the health and well-being of children and their families as a whole.

… health visitors that are training now haven’t done routine development clinics to compare to see what’s normal … it takes a wee while to see enough of the variations to know how big the variation is, to get a feel for development issues, and to know when to start worrying. (HV7)

I think de-skilling yourself (is a concern) because you are not doing the check-ups … I know that 99% of the children you see are fine … but it is still about the contact and particularly 2-year checks, mums would often have queries, or temper tantrums, or sleepless nights, potty training … they don’t come to you with that any more. … (HV3)

Health visitors referred to the importance of contact with all children and families over time as a central aspect of their practice through which expertise was developed in depth and in breadth. This concern about the changing nature of health visiting expertise was exacerbated by a coinciding increase of focus and time spent on child protection work. Health visitors highlighted that child protection work was not a new aspect to their work. However, whereas, before it had been an aspect of their overall practice, it was...
increasingly becoming the focus.

... it's sad because I think that we're getting really focused into child protection, which we're all involved in ... but none of us want to be social workers ... it's like a role we're getting sort of pushed into ... from something that was universal and hit a lot of boxes which highlighted things. We've been gawed and gawed and we're not using our skills to the best that we could. (HV14)

More and more the child protection side of things is shadowing (health visiting practice). (HV1)

Central to health visitors concerns about the increasing emphasis on child protection work shaping health visiting practice was, again, the loss of regular contact with most families. Whereas before contact with all families had allowed for a bottom-up approach, whereby the needs of individual families could be responded to in a timely way, reduced contact with families had led to a more top-down approach, focused on child protection work with some families. It comes back to that universal thing, if you're calling everybody in at 2 years ... then 99% of the people will turn up so ones you're chasing are the chaotic ones ... you've seen all these other kids and any of them that may have a wee bit of a problem with something you're obviously seeing to that. (HV14)

For health visitors the increasing focus on child protection work had implications for their practice, but also for their profession, and had been a contributory factor to low morale within the profession, which I explore further in the next section.

THE HEALTH VISITING PROFESSION AND MORALE

In the interviews there was often a palpable sadness when health visitors spoke about how limited they felt the scope of their practice had become following Hall 4. Health visitors expressed this emotional cost and a sense of low morale in many ways using terms such as feeling ‘saddened’, ‘distressed’, ‘disappointed’, and ‘vulnerable’, and that their work had been ‘rubbished’.

I think it (health visiting) has been totally eradicated just about. I think we all kind of feel vulnerable that things we did in the past have all kind of been rubbed up ... and for years ... we did it ... I think the whole service is quite demoralised. (HV3)

I feel saddened. I think it's an erosion of the service. I feel that people were getting a good service ... but ... the new first-time mothers coming in don't know what they have not had so they are not going to miss it. So it's easy to erode away the role of the health visitor because you don't know what you've lost. (HV15)

Irrationally, a policy response which aimed to maximise limited resources had, health visitors’ accounts suggested, acted to increase the rate at which health visitors would leave the profession, hence limiting available resources further.

The (Government) are saying, Health for All Children ... and, the people to deliver it are us, and there isn't anybody of us, and it is distressing that nobody cares ... our sickness rate will increase, and people who can take early retirement will, and so it goes on. (HV8)

Many of the health visitors interviewed talked about their increasing caseloads and the decreasing number of health visitors. Health visitors talked about the impact of this on morale and often expressed a sense of despair with suggestion that the value of health visiting, which they recognised from working directly with children and families, was not being recognised within policy discourses.

DISCUSSION

The findings reported in this paper are drawn from a small-scale study which aimed to explore the impact of Hall 4 and which took place within one NHS locality in the United Kingdom (UK). A limitation of this study may be that the fieldwork was carried out in 2007 and 2008, which was prior to developments within the respective countries of the UK to increase and campaign for an increased number of health visitors.

This was also a critical time period, however, for the study of the impact of policy change on practice. Sufficient time had lapsed following Hall 4 implementation to enable health visitors to reflect on the implications for their practice, but it was prior to the proposed increases in the health visiting workforce. A second limitation to the study is that it was carried out within one NHS locality, which does not reflect the possible diversity of policy and practice contexts across the UK.

The findings reported in this paper highlight that health visitors felt that Hall 4 had been imposed on their practice and that, as ‘street-level bureaucrats’ (Lipsky, 1980, 2010), health visitors felt that they had very little voice in the process of policy change. Further, the study findings suggest that health visitors had concerns about the impacts of Hall 4 on health visiting expertise and on child protection work increasingly being the focus of, rather than part of, their practice. This trend is reflected in other studies. Hogg et al (2013), in a study exploring the use of an assessment tool used to assess families’ vulnerability after the implementation of Hall 4, found that health visitors were often limited in the support they could provide families due to limited resources and a managerial focus on the child protection aspect of health visitors’ caseloads.

Other studies exploring health visiting practice have also suggested that a bottom-up approach working and having contact with all children and their families enables health visitors to identify when families are in need of support and to provide it in a timely and resource-efficient manner (Williams, 1997).

For health visiting practice and for the health visiting profession the findings of this study suggest there has been an emotional toll. The health visitors’ accounts suggest that this emotional cost was experienced by individual health visitors, and collectively as a profession, as low morale. Machin and colleagues (2012) highlighted the importance of health visitors’ collective identity in enabling health visiting practice and performance. The findings from this study would suggest that the period following the implementation of Hall 4 morale of the health visiting profession was low, which has implications for individual health visitors in terms of job satisfaction, for the collective identity of health visiting as a profession, and for children and families.

The health visitors’ response to Hall 4 and its impacts on their practice may have similarities to what Ceci (2003) refers to as ‘midnight
reckonings’. This is where health visitors are able to be both rational practitioners, maintaining a coherent self, and at the same time to have grave doubts over the direction of travel of health visiting practice. The findings of this paper suggest the importance of listening to these doubts when developing policy which will impact on health visiting practice.

CONCLUSION
This paper has explored the impact of Hall 4 on health visiting practice and the health visiting profession. Health visitors’ accounts suggest that changes to practice following Hall 4 impacted on health visiting practice and on the morale of the profession. Health visitors play a crucial role in implementing policy as it is their practices which shape how families experience it. The findings of this study highlight the importance of listening to and engaging with the practice-based experience of health visitors and the need to pay attention to preparing and supporting change when developing and implementing recommendations from policy which directly impact on the profession and their work with families.

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Using social networking sites (namely Facebook) in health visiting practice – an account of five years experience

INTRODUCTION
Effective communication has been a cornerstone of health visiting practice from its inception, when women visited impoverished inner city families to deliver key health messages (Hale et al 1968), to today. Methods and forms of communication with clients have changed considerably and beyond recognition in some instances since those early days of health visiting. From face-to-face communication as the only method in early years, to written messages, telephones and, most recently, electronic methods, health visitors have had to and will continue to embrace new ways of communicating with clients throughout their careers.

Currently the use of social network sites as a form of communication is soaring. From information released for the first time by Facebook in 2013 (Reuters 2013) over 24 million people in the UK, almost half the population, visit their Facebook page every day. Although valid research into the use of Facebook in the UK is scarce the numbers indicate that social networking sites are as valid a means of communication as any other. If it is relevant to encourage health visitors to communicate with each other using social media (Chinn 2014), then, used with propriety, it should be equally relevant for health visitors to communicate with clients in this way. This paper describes the journey of setting up and developing a health visiting Facebook page, explains how, over five years, it has been embraced by staff and clients, relates the feedback received from clients and explains the governance in place to support its use in clinical practice.

Whilst the benefits of social networking in health visiting practice are highlighted there are disadvantages of technology in health care which can negate its usefulness, particularly if a computer is seen to be ‘dominating’ an interaction (Greenhalgh et al 2014). Although out of the scope of this paper they are important considerations.

RATIONALE FOR A PILOT STUDY IN THE USE OF SOCIAL NETWORKING
The pilot was initiated within the health visiting team caseload of 250 families. The caseload is in the heart of Poole’s most deprived area based on national quintiles of the Index of Multiple Deprivation 2010 by Super Output Areas (Public Health England 2014). The average age of mothers at the time of the birth of their first baby is 23 years and 74% are White British. 14% were unemployed at the time of the birth of their first baby. Telephone landlines are rare and mobile numbers change as frequently as addresses. Considerable time was spent trying to contact mothers receiving a ‘universal plus’ level of service based on identified ‘vulnerability’ or ‘risk’ factors (DH 2009).

The clients’ Facebook page identity, however, is the one communication link that appears (from experiences in contacting them) a constant in their lives. In September 2009 following a particularly unfruitful day the health visiting team discussed the merits of using social networking sites, namely Facebook, which clients frequently referred to as a primary source of communicating with friends and family.

All believed in the benefits that using Facebook could bring to clients who could use both the private messaging service which is a confidential form of communicating and the public page that serves to advise and inform on general issues, including local events. This has added...
financial benefit to the Organisation as Facebook allows effective communicating to multiple clients promoting health at minimal cost. More importantly, the team also believed that the use of Facebook would provide a communication tool for their hardest to reach clients.

‘Hard-to-reach’ clients include those who are ‘targeted’ for early interventions based on assessment of need in accordance with the Healthy Child Programme (DH 2009). These clients as Barlow et al (2005) found, choose not to engage with services offered for many different reasons including misperceptions and misgivings about the service and a lack of trust. They are rarely in for a pre-arranged home visit, frequently change mobile phone numbers and do not initiate contact. It is important for health visitors to reach these clients as there is evidence that effective early intervention projects can have short and long-term benefits on children’s educational, emotional and behavioural outcomes (Tickell 2011).

The belief that the use of Facebook would be an effective communication tool was soon realised. During the first year of the pilot, fourteen out of forty clients who joined the health visiting team’s Facebook page were considered by the team as ‘hard-to-reach’. Five of those fourteen clients were not contactable through the information held by the health visiting team or GP practice but did respond through a private Facebook message. Two families had moved out of the area and left no forwarding address and had not registered with a new GP surgery and the rest had changed address and phone numbers without informing the GPs or health visitors. Communication through Facebook led to these being rectified.

ESTABLISHING THE FACEBOOK PAGE

The Facebook page was set up by a member of the health visiting team with considerable personal knowledge and experience of Facebook and the health visitor (the author) who has considerable knowledge and experience of information governance. Simultaneously, the health visitor worked with the Trust’s governance team to validate the project as a formal pilot based on the benefits that using social networks could bring to the Trust in helping engage ‘hard-to-reach’ clients.

A guidance document was also developed to underpin the importance of governance within the project and to allay fears of misuse, understandably raised by colleagues and managers. The document explains how and when Facebook should be used; the use of disclaimers to ensure that all clients understood their responsibilities in any information posted; the importance of security settings to ensure the membership is restricted to members of the health visiting team’s caseload and the application of existing codes of conduct and ethical considerations for staff (NMC 2008).

Setting up a new Facebook page is instant and easy. All members of the team were familiar with its use having their own pages for some time. Clients were notified of the additional service and method of communication by way of a small flyer given out during the ante-natal or post-natal visits. They were invited to join the ‘group’ and advised that it is only for clients registered with the health visiting team’s surgery to help promote a sense of unity and protection (there were concerns raised by staff that ex-partners could try and access the site for information).

As part of the governance process, the top of the team’s Facebook page contains a clear message about what is acceptable and what is not, both for safety and for clients’ protection (it is rare that people need to be reminded of it, and those occasions have been when a mother has asked questions relating to an ill child where a telephone conversation would have been more appropriate).

‘Welcome to ….. Facebook Page We welcome comments and contributions from group members and questions about parenting, child behaviour and health related topics. To be safe, please do not use Facebook to seek advice if your child is ill but speak to us face-to-face or on the phone or seek medical help if you are worried.

Please remember you are responsible for any information or pictures of you and your family that you post on our page.

Comments that are offensive or of a personal nature against any person – either a member of staff or another parent will not be tolerated. We reserve the right to remove any group member at any time’.

The page also provides information about the health visiting team – who they are, hours of working and alternative contact details, including the doctor’s surgery and NHS Direct.

MESSAGES AND USE

Messages and postings have not changed significantly in over five years of use. Health promotional messages and information about local activities is a predominant part of the postings from the health visiting team. They are short, succinct and informal. Examples include raising awareness of the problems for young children that noise from fireworks can have during the approach of November 5th; reminders about fire risk from candles and tree lights around Christmas; information about breast-feeding week, ‘bug busting day’, ‘no smoking week’ and so on. The advantage of this method of raising important health messages via Facebook, is that by including an instant link to the relevant official web-page the client instantly has all the information they want or need. As an example:

‘Next week is Child Safety Week. Accidents are one of the biggest dangers to children. You can do a huge amount to keep your child even safer! Go to www.capt.org.uk for more info (but just in case, its a good time to check your kitchen and make sure there are no nasty chemicals in your child’s reach and are your smoke alarms working?)

Once clients have been accepted on to the Facebook page as part of the client group, they are welcome to put their own postings on after being reminded of the notice at the top of the page. Postings vary but are most frequently questions about the times of groups or clinics, (‘Is there anything on in the afternoons for both over and under ones’); advice for feeding issues or behaviour (‘Can anyone help with my little lad who has started to throw himself to the floor when he gets upset and I’m worried he will bang his head?’) and to pass on information about a new activity or group they have found in the neighbourhood. All very much the questions and discussion topics normally raised within a clinic situation.

The page is attractive to young mothers, in particular, and/or those who find it very difficult to pick up the telephone and initiate a contact. They will frequently post messages requesting a team member telephone them – ‘Please can someone contact me regarding my daughter c…..

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My number is …. or will ask questions for advice - ‘Do babies go off their food when they are teething?’ or ‘Is it ok to put ****** on no3 size teats he’s on S. 7oz bottles been using no1 teets bt now he’s 12weeks need to up the teets n all lv gt is no3’

(Reply) Give it a go. If he struggles with the faster flow would suggest getting some 2’s

(Client) Had two bottles now and drank them in 25mins and no reflux or sickness and settled quit happily and stayed awake though the feed

The frequency of questions about issues that would normally warrant a phone call or a visit to clinic indicates how Facebook is a preferred method of communication for many clients.

CLIENT SATISFACTION AND BENEFITS

Clients make a choice whether or not to join the health visiting Facebook page. Out of 51 mothers who have had a baby in the past year, over 61% have joined (more work is planned to ascertain the reasons why clients do not join). Their feedback and responses to information posted is given via their comments or by clicking ‘like’.

This means the team can monitor how many people are viewing information posts.

Last year clients were asked how satisfied they were with the Facebook page. Twenty-three members responded, mostly by clicking on ‘like’, but several returned positive comments.

‘It’s great, I can contact you when its convenient to me even late in the evening, and I always get a response by the next day.’

‘I dont always have credit on my fone to make calls, but using facebook is handy. I like that I can send messages about anything and its ok’.

‘I keep up to date on here as i use Facebook often please keep it’

‘Its such an easy way to ask anything when I need to, and I like the messages you post’ ‘like, like, like, a lot’

The use of Facebook provides an additional benefit as staff can still communicate with clients when they are not able to get to their base, such as during adverse weather conditions. Last winter during heavy snow staff could log-on to the Facebook page from home computers and communicate with clients to warn of cancellations of local groups. They were also able to continue to give advice and information if needed and clients were able to access a service, albeit limited, which would otherwise not be available to them.

Perhaps most beneficial of all is the support clients can give each other via the page. This is noticeable when young mothers feel anxious about accessing a group, despite considerable efforts to support them.

This brief but effective dialogue below is from an exchange initiated by a client. Although all the information had been given to her by the health visitor she found the support she needed from the Facebook page to access a swim and gym group and remains a regular attender.

‘Hi im a bit rubbish with attending groups and have decided i really want to start attending what are the best ones for a one year old. I dont really know anyone with a child being one so dont know what is the best option xx’

‘Hi I go to swim and gym on a thursday with my almost 20 month old. Id be happy to meet you if you like we are going tmoz. I also go to the weds group at the children’s centre too but only last half as we have gymnastics first. Maybe see you tmoz. Its a great group and all u need is swimsuit and swim nappy. They have floats and rubber rings for baby xx’

‘I’m not able to go tomorrow but next week that would be nice. hopefully see you wednesday xxx’

Even if the use of Facebook paves the way for only one family to access groups that make a real difference to the child’s life where they would not have done otherwise the benefits outweigh any risk or cost, as the use of it does not take additional time or resources; the communication, that the health visiting team would normally engage in, is merely in a different form.

One of the main benefits to health visitors underpins the initial reason for pursuing the use of Facebook, which is to contact people who have moved and/or changed telephone numbers. A young mother (‘Ms S’), moved to a small town several miles away and registered at the new GP practice. The new health visitor contacted the health visitor to say she had tried to contact ‘Ms S’ on several occasions: her mobile telephone number no longer worked; she was not in on two occasions that the health visitor called at the address ‘Ms S’ had given on registering at the surgery and nor did she respond to messages left; The health visitor was increasingly concerned. Following a ‘private message’ to ‘Ms S’ via Facebook, she responded within an hour. She said she had not thought it relevant to respond to messages through the door, but after receiving the Facebook message she gave a working mobile telephone number and contact was established with the new health visitor.

SUPPORTING HEALTH VISITING PRACTICE

Promoting health and well-being and advising on health matters is a cornerstone of health visiting practice (NHS 2014). In Dorset all community practitioners within the Trust have recently been provided with ‘notebook’ computers to progress towards paperless practice. Used with sensitivity and not seen to dominate the interface between client and practitioner (Greenhalgh et al 2014) this technology provides great new opportunities to deliver health information in a way that is meaningful to clients and stimulating.

Neural development, for example, as explained by Price et al (2011) is brought alive through dynamic visual imagery and innovative film techniques. Having instant information in an illustrative and animated form is also beneficial in other situations such as supporting mothers intending to breast feed by showing good latching methods and positioning (provided websites are bona fide). Weaning and feeding suggestions are also well demonstrated through short film clips that help support information given by the health visiting team. All film clips used by the team can be directly accessed from the Facebook page. Clients thus know the information offered electronically is as safe and evidence based as any other they are given.

For some parents, hearing information directly from people they know and trust but in a way they can watch in their own time is an effective way of learning. The health visiting team recently made a short film about weaning and infant nutrition which is linked to the health visiting page. In addition, to weaning discussions clients are invited to access the clips which they
The use of information technology and social networking sites does not come without concerns related to ethics, information governance and ease of use, all of which are comprehensively discussed by Azizi (2013) and Greeghalgh et al (2014).

The project was presented to the Trust’s senior managers, and governance leads during which the governance processes were closely scrutinised but approved. Risks were acknowledged but the mitigation measures and benefits led not only to Trust approval but for their request for the use of Facebook to be rolled out across other health visiting teams.

During the early roll out process in which teams were visited and provided with a demonstration of the use of Facebook, several staff members repeated the concerns raised by managers and remain wary despite the robust guidance to protect both staff and clients.

Concerns are based primarily on the risk of breach of confidentiality and of offensive language within messages posted on the Facebook page. But for every concern there are clear mechanisms in place to prevent them or minimise their risk, which are explained fully within the guidance. Mechanisms include:

1) The health visiting team acts as ‘hosts’ of the Facebook page giving them full control over who is ‘accepted’ as a member of the group.
2) The health visitor informs the client of the Facebook page during post natal visits and explains ‘responsible’ messaging and general etiquette.
3) If a message or picture posted by a client is deemed offensive or inappropriate in any way, any team member can delete it instantly they see it.
4) If any members act inappropriately their access to the page can be stopped.
5) Clients have the choice to join the group and participate in the public part of the page or to just use the private messaging service to communicate with the team.
6) The disclaimer is permanently at the top of the page to remind clients that Facebook is not a means to contact the health visiting team urgently especially if their child is ill and gives alternative contact details.

With the use of notebooks and availability of an almost infinite amount of information to pass on to clients, health visitors face a future that heralds new risks in terms of giving misleading or wrong information from web-sites that are not bona fide or approved by the employing Trust. This, however, is not new to practitioners and ensuring all information, from whatever source, is evidence based, appropriate, suitably presented and ethical is fundamental to practice and underpinned through professional codes of conduct and ethical guidance (Azizi 2013, NMC 2008).

CONCLUSION

At a time when electronic communication and the use of the Internet is one of the primary methods of communication Facebook provides health visiting teams with a method of working with clients in a way that enables people to respond in their own way and when they wish, at any time of the day or night. The benefits to the clients, as expressed by them, are evident.

Like Azizi (2013) concludes, social networking sites provide good opportunities to share information and useful educational resources - but there are pitfalls. With robust guidance in place to protect both staff and service users and to satisfy NHS governance requirements, the use of social networking sites as a communication method with clients can be hugely beneficial. Although Facebook may be dominating the market currently, new ones are emerging all the time. All provide opportunity for creativity and innovation in health visiting practice to help keep the service relevant to families at a time when electronic information and communication is the predominant form of communication. If health visitors are to continue offering a relevant and effective service to improve the health and wellbeing of children, it is recommended that they embrace new and developing methods of communicating which the parents of those children are using.

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Key points

- Social networking is now a key communication method
- Almost half the population visit their Facebook Page every day
- Social networking with clients is an effective and efficient communication method for health visitors
- Robust guidance can effectively address concerns relating to information and clinical governance
- The use of Facebook in this pilot study is appreciated by clients and improves engagement with the service
- Information Computer Technology can enhance health promotion and education amongst the client population.

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The unmet concerns of twins with special needs: diagnostic challenges and service recommendations

**INTRODUCTION**

Assisted reproductive technology (ART) and older maternal age have increased the frequency of twin and higher order multiple births (Mathews and MacDorman, 2011). Between 1980 and 2004 there was an approximate 70% increase in the number of twins born in the US (Martin et al, 2012). Since 2009, the twinning rate has fluctuated from only 33.2 to 33.1 per thousand births. The number of infants born in twin deliveries was 131,024 in 2012. This figure, while the lowest number in almost a decade, remains nearly twice as high as the number of twin deliveries in 1980, which was 68,339 (Martin et al, 2013). Most twin pregnancies experience relatively shortened gestational periods, posing greater physical risks to mothers and infants (Malmstrom and Biale, 1990). It has been well established that premature births increase the probability of a child having special needs (SPNs), defined as any physical or mental disability (Blickstein, 2002). The increase in twin births means a greater number of twins with SPNs. Very limited research has focused on the health and social needs of mothers and other caregivers of SPNs twins (Harvey et al, 2014). There is evidence that affected families experience unique diagnostic difficulties (Spratt et al, 2007) and resource challenges (Heiman, 2002).

**BACKGROUND**

Families of children with SPNs often experience difficulties when obtaining and accepting a diagnosis for their child. Specifically, parents report feeling that they were not provided with adequate information about their child’s diagnosis and helpful resources (Bourke-Taylor et al, 2010). Interviews with mothers of affected children reported difficulties in coping with their child’s SPNs, and trying to resolve the feeling of grief from ‘losing’ the child they had expected (Green, 2007).

For some parents, having a SPNs child is overwhelming. Families who knew or suspected that their child would have SPNs prior to birth (eg, Down syndrome) reported some relief once the diagnosis was available (Heiman, 2002). By receiving a diagnosis parents could work to obtain resources for assisting their child (Spratt et al, 2007). Parents whose children were diagnosed at birth, or soon after, indicated greater coping skills than parents whose children were diagnosed later. The difference was believed to occur due to the former having had time to adjust their expectations. Once given a diagnosis, parents typically tried to obtain resources for their children. However, parents have reported various obstacles when trying to identify and obtain these resources. Interviews with mothers have revealed challenges with receiving accurate information about services, service availability and paying for services that were not state-provided (Heiman, 2002). Mothers of twins have reported an imbalance between needed and received support to care for their children (Harvey et al, 2014). These mothers reported even greater needs for guidance and support when caring for premature twins.

Green (2007) interviewed mothers of children with SPNs and found that many mothers were forced to advocate on their own behalf to obtain and maintain resources for their children. Mothers have reported experiencing parenting stress and challenges with their typically developing children, but emphasized additional stress due to the energy and time commitment required to seek SPNs resources. These challenges intensified when dealing with services that were not comprehensive and/or communications included poorly informed or unresponsive providers (Bourke-Taylor et al, 2010).

Given the limited types of services available to families of children with SPNs, it is vital to identify which services are most beneficial. This knowledge is requisite for providing support for the continuation and improvement of these...
services. Having children generally reduces resources available to families; therefore, having SPNs twins can result in greater resource deficits compared to families with affected singletons. As programs experience reduced government funding, programs experience reduced ability to provide family services. Therefore, it would benefit the field to have a greater understanding of the needs and experiences of families of SPNs twins.

**STUDY AIM**

The present study, conducted in the US, aimed to enhance understanding of the circumstances surrounding parents' experiences of receiving a SPNs diagnosis for one or both twins. Examining the diagnostic circumstances and challenges experienced by these families could improve diagnostic services and treatments. Beneficial and less beneficial services were also compared.

**METHOD**

**Ethics**

Approval for the study was obtained from the Institutional Review Boards (IRB) of each institution. Individuals interested in participating were sent an informed consent form and the survey. Potential participants were informed of the voluntary nature of the study and assured that declining to participate would not affect their relationship with the university. Identifying information was removed or held in confidence, with only the primary investigators having access to participants' identities. Completed surveys were stored in a locked laboratory.

**Participants**

Participants included 30 mothers with monozygotic (MZ; n=8) and dizygotic (DZ; n=22) twin pairs. Within twin dyads either one (n=19) or both (n=11) twins had diagnosed physical or mental SPNs (see Table 1). Parents were recruited through advertisements in Twins Magazine and e-mail advertising via local and national mothers of twins clubs. Given the limited knowledge base on families of SPNs twins, parents of twins with SPNs were recruited regardless of type and severity.

Mothers’ and fathers’ ages ranged from 26.64–53.02 years (M=38.31; SD=6.28), and 31.46–59.32 (M=40.02; SD=6.93), respectively. The majority of participants identified as Caucasian (78%) or interracial (12%). Parents were highly educated with the majority having earned college or graduate school degrees (83%). A high proportion of both mothers and fathers identified as having professional or managerial occupations (67%); some mothers were homemakers with college degrees (43%). Most families (63%) had conceived twins through ART.

**Child information**

Twins ranged in age from 10.46 months–8.88 years (M=3.59 yrs; SD=2.06). Gestational periods ranged from 24–39 weeks (M=33.43; SD=4.04). The average birth weight (M=4.37 lbs; SD=1.96) was below the national twin average of 5.4 pounds (Brown and Isaacs, 2008). Infants born at extremely low birth weights (<2.2 lbs) are at an increased risk for SPNs (approximately 23% for neurodevelopmental disorders; Wilson-Costello et al, 2007). Many twins in the current sample experienced low birth weights (<5.5lbs), thus posing an increased risk for having SPNs, due to correlations between low birth weight and relatively short gestational periods (Martin et al, 2011).

Fourteen families reported having other children, four of which having SPNs. A wide range of SPNs was reported in the current sample. Most children experienced a form of neurological disorder (including cerebral palsy and spinal bifida; n=12), language impairments (n=9), autism spectrum disorder (n=7), chronic lung disease (n=7) and Down syndrome (n=6).

**Materials**

Mothers completed the Twins with Special Needs Survey (TSPNs) developed at CSU Fullerton by the first author. This survey assessed the diagnostic and resource experiences of families with one or two SPN-affected twins. Information was provided through short-response explanations. A standard physical resemblance questionnaire diagnoses the zygosity of the twins (Nichols and Bilbro, 1966).

**Procedures**

Short-answer responses were coded for themes using framework analyses (Krueger and Casey, 2000). Two independent researchers developed an initial coding scheme to evaluate each short-answer response. Discrepancies were discussed and resolved between researchers and a final coding manual was developed. Two different research assistants used the final manual and recoded the surveys. Discrepancies were discussed and resolved.

Given that some parents received multiple types of diagnoses, services and/or challenges, the number of responses exceeded the number of participants. For example, some parents suspected that their children were experiencing poor speech development; therefore, they requested a developmental assessment. The previous example would have received two codes (1: Delayed Development and 2: Early Intervention Testing/Developmental Screening). Some questions required parents to provide a list of responses (eg. ‘Which resources have you received?’), while others allowed for greater elaboration (‘How was your child[ren]’s special need[s] diagnosed?’). When questions allowed for greater elaboration, sample quotes of participants’ responses are provided for contextual detail.

**RESULTS**

**Diagnosis: Parental Responses**

Main parental concerns centered on receiving timely, accurate diagnoses and determining the best treatment. To assess the diagnostic experiences of these families, potential contributing factors (eg. pregnancy difficulties) and diagnostic backgrounds (eg. diagnostic challenges) were examined. Twenty-four mothers experienced physical challenges during their pregnancies, including pre-eclampsia, shortening of the cervix, and thyroid problems. Twelve mothers experienced delivery difficulties, some of which included needing oxytocin to stimulate labour, abnormal fetal heart rhythm, and placental abruption, with 27 mothers having a cesarean section (emergency or elective).

Within the 30 twin dyads (n=60 twins), 41 twins were diagnosed with some form of SPNs (68%). Age at diagnosis for the 41 twins ranged from zero – 42.6 months, with zero representing a diagnosis received prenatally, or within the first 15 days after birth. A small number of parents were cognizant of having at least one child with SPNs before birth (n=3), yet other parents reported being concerned prenatally (n=1) or soon after birth (n=12). Prenatal diagnosis was given following prenatal testing or pregnancy difficulties, detected via ultrasound and amniocentesis. Concerns also developed when families experienced late preterm (34 - 36 weeks) or very early preterm (less than 32 weeks) births.

**Diagnosis**

A wide range of SPNs was reported in the current study. Fourteen parents had children with multiple SPNs, ranging from mild to severe (eg. autism spectrum disorder, Down syndrome, cerebral palsy, lung disease and...
Professional and research

developmental coordination disorder). There was also diagnostic variability within families with two SPNs twins (see Table 1). Although there was variability in the types of diagnoses, there were substantial similarities in how diagnoses were made and delivered.

Information Delivery
Parents described how their child(ren) were diagnosed. Diagnostic details were coded into four categories: pre-natal and post-natal testing, early intervention (EI) testing, delayed development, and physical symptoms. For many parents (n=10), diagnoses were achieved through prenatal or postnatal testing and were typically performed due to premature birth and/or low birth weight. Some diagnoses were made due to parents having observed atypical physical symptoms like severe allergies, asthma, and illness, suggesting a chonic SPN: ‘Her first ER visit was at 4 ½ for an asthma attack, this was when we really learned more about her disease, care and treatment’. Other twins were diagnosed after failure to achieve expected developmental milestones in speech and/or motor development. Observed developmental delays resulted in parents pursuing developmental screening to confirm suspected diagnoses.

Diagnostic Challenges
The majority of parents received sufficient information about their child(ren)’s SPNs; however, 17% of parents experienced diagnostic challenges that fell within one of two categories. The greatest challenge was receiving inadequate information about their child(ren)’s SPNs and the types of services parents were qualified to receive. Parents desired more verbal information to help them care for their children. It was critical for parents to know the specific symptoms associated with their child(ren)’s SPNs and how their behaviors differed from those of non-SPNs children:

‘I was never told that they would NOT cry when hungry or that being lethargic was normal.’

The limited information provided by practitioners and service providers encouraged parents to become self-reliant in educating themselves, mostly through Internet searches. However, most parents did not receive sufficient information about which services were available. Parents wanted greater information regarding the services for which they qualified, regardless of whether they requested information about such services:

‘I did have complaints with the ‘system’ in that they never told [me] what services where available - they only asked ‘what do you want?’

The second key diagnostic challenges parents faced were working with inattentive doctors and receiving delayed diagnoses for their children. Parents attributed the late diagnoses to practitioners having insufficient follow-up time or availability, to practitioners not being proactive and to medical personnel not having completed adequate testing to reach a diagnosis:

‘The doctors had to be made aware of the issues by me as no one doctor was seeing all of the issues and could not make a diagnosis.’

Services/Resources Received
Parents identified resources and services they received for either twin after their birth. Similar services were grouped together based on specialization. The list of services received was categorized into six groups. The top three services included early intervention (EI) occupational therapy (OT; 22%), physical therapy (18%) and therapy/other (18%). The therapy/other category included all other reported therapies, such as applied behavioral analysis, swallowing therapy, developmental social groups and vision stimulation. Services categorized as ‘Other’ (15%) were reported as the fourth most received services. The ‘Other’ category included support services such as respite care, woman, infants and children (WIC) services, social workers, and classroom aid. Speech therapy (14%), followed by receiving assistance from various types of specialists (13%; eg, lactation specialists, neurological testers, special educators and Neonatal Intensive Care Unit (NICU) extensive care treatment personnel), were commonly received services.

Resources Desired
Parents indicated resources or services they desired, but had not received; such services were unmet or desired resources. Nearly half the mothers (47%) reported having unmet resource needs. Four categories emerged, with the most desired resources including training to care for, and in some cases communicate with, their SPNs children (eg, lactation training, sign language classes and home nurse visits). Services desired also included earlier receipt of services and having services provided for longer periods of time: ‘The services didn’t start until the twins were 6 weeks old. The hospital staff were wonderful, but once I left I was on my own.’ Parents reported a need for respite care (the wish to receive it or receive more of it), and counseling services. Desired counseling services included marriage, grief and counseling specific to families of children with SPNs. Lastly, 87% of the parents reported a desire to have contact with other parents of twins with SPNs.

Services Not Considered Beneficial
A small number of parents (n=4) indicated there were state-provided services they found least beneficial or insufficient. Service ineffectiveness sometimes resulted in families having to find and purchase private services of higher quality.

DISCUSSION
Diagnostic Challenges
The majority of the parents received adequate diagnostic information, with only 17% reporting inadequate information. The large number of parents with adequate diagnostic information could be associated, in part, by high educational and employment status of the families in the current study, paralleling other research findings (Green, 2007).

Even though a small proportion of parents in the present study reported receiving inadequate diagnostic information, this area of concern can have lasting effects. Having a delayed or inappropriate diagnosis can jeopardize the benefits of the services that are received and considered appropriate. For example, late diagnosis delays the onset of timely interventions. Misdiagnosis could result in inappropriate interventions and place unnecessary financial strain on families. Financial strain is a common concern among mothers of twins (Harvey et al, 2014), and can increase when caring for SPNs children (Green, 2007). Parents in the current study suggested that to minimize
delayed diagnosis or misdiagnosis, the same practitioners should provide more routine follow-ups. Unfortunately, more frequent appointments may place added financial strain on families.

Services
The large amount and variety of reported resources suggest that the challenge for parents is not the lack of resource availability, but the lack of knowledge about resources. Parents reported being overwhelmed when they learned about their child(ren’s) SPNs. Parents who reported receiving their child(ren’s) diagnosis in early childhood reported researching symptoms and services on their own, suggesting they may have been less overwhelmed when the diagnosis was provided. Comparatively, parents of children diagnosed as infants without original suspicions of SPNs report being severely overwhelmed with diagnostic information. Many parents of early-diagnosed children lacked knowledge of whom to contact for assistance. To serve families during such challenging times, practitioners or hospital staff should gain a better understanding of the specific needs of these families (Harvey et al., 2014), followed by:

• Listing resources often obtained by families of twins with SPNs.
• Suggesting specific services for which the twins may qualify.
• Providing information in a comprehensible way, such as a brief booklet listing key points.
• Informing parents of the likelihood of the currently ‘unaffected co-twin’ to developing the same SPN.

SPNs services should also consider the needs of the family unit and develop comprehensive services, such as:

• A program that enables caregivers to obtain services at one location (Rivers and Stoneman, 2003).
• Family centered services that afford flexible, individualized plans (Bourke-Taylor et al., 2010).
• Caregiver retreats to offer contact with other parents of SPNs twins.

There are programs for caregivers of individuals with SPNs, such as the US-based Caregiver Retreats held by Ability First in Crestine, CA. These retreats enable caregivers to share their experiences. Many parents feel isolated when caring for a child with SPNs (Green, 2007), a situation that can be compounded when caring for twins with SPNs (Spratt et al., 2007). Having contact with other multiple birth families could:
• Provide friendship for the children and support for the families, thereby reducing social isolation (Heiman, 2002).
• Allow caregivers to educate each other about available or beneficial services.
• Develop local support groups/workshops to help families transition.
• Provide information to other parents that may not be provided by practitioners, eg., organizing appropriate play dates (Carpenter, 2000).

LIMITATIONS AND FUTURE DIRECTIONS
Consideration should be taken when interpreting the current results. The participants were self-selected and provided self-reported information regarding services received. The current sample also included an overrepresentation of highly educated and well-informed families, raising the possibility that challenges for low resource parents were somewhat overlooked. Furthermore, due to the overrepresentation of families with DZ twins, zygosity comparisons could not be completed. The current sample consisted of parents of twins with a range of SPNs and severity. Resource needs will vary by SPNs type and severity, emphasizing the importance of applying a flexible approach to program development for families. Finally, parents of twins with SPNs are a unique subset, so the findings may not generalize beyond the multiple birth community.

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EMBRACE YOUR AUTONOMY
BE PROUD TO BE A NURSE PRESCRIBER!

All new specialist community public health nursing students about to undertake the V100 prescribing course and those who have recently qualified as community practitioners should embrace their prescribing role, says Louise Perrin

**BACKGROUND**

Nurse prescribing first came about following the Cumberlege Report, *Neighbourhood Nursing: A Focus For Care* (Cumberlege, 1986), which recommended that nurses should be able to prescribe from a limited formulary. The *Crown Report* (DH, 1999) later endorsed nurse prescribing, and nurses were finally recognised for the important role they were already playing in both prescribing and in health promotion.

First, there was a pilot project and then further groups were targeted in 1999 before prescribing was rolled out in 2001. The initial pilot projects identified nurse prescribers’ anxiety as an issue due to their concerns about accountability (Luker et al, 1997). Subsequently, Lord Darzi’s report, *A High Quality Workforce: NHS Next Stage Review* (DH, 2008) provided a focus on the NHS, increased funding and the empowerment of staff to take up training and education. This formally recognised continued professional development (CPD) as ‘vital’ to professional practice. If you have been fortunate enough to secure or

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As a new nurse prescriber be reassured that your knowledge will be current and up to date, as well as grounded in your past practice.

As a registered nurse or midwife you will have already practised and developed both your knowledge and skills of the consultation process, assessment, care planning and medicines management.

The V100 course is a natural progression in developing your practice, skills and knowledge as you move into public health as an autonomous practitioner.
have recently completed a nurse prescribing module, take advantage of this exciting opportunity to develop your role and keep sight of the benefits of prescribing.

**PRESCRIBING PRACTICE**
The Nursing and Midwifery Council (NMC) publishes regular reports on its members. The statistics show a gradual increase in registrations of nurse prescribers each year. The most recent showed that in 2010, there were more than 54,000 nurse prescribers (Royal College of Nursing (RCN), 2012). However, Hall et al (2006) suggest only 50 per cent of health visitors with a V100 qualification prescribe for their clients, and further studies cite evidence a low level of prescribing activity (While and Biggs, 2004; Thurtle, 2007, Young et al, 2009; Brooks, 2013).

While we are aware of poor engagement in prescribing, there has been little research to actually explore the reasons for this. A study by While and Biggs (2004) provides us with an insight into the prescribing habits of health visitors. They conducted a postal study of health visitors and district nurses in three PCTS in south England and found 6.8 per cent wrote up to one prescription a week, 23 per cent wrote between one to three a week, and 8 per cent had never prescribed since completing their training. Prescribing was also higher among district nurses than health visitors. It is interesting that more than two-thirds reported the Nurse Prescribers’ Formulary (NPF) (British Medical Asssociation (BMA), 2013) did not cover their prescribing needs and gave examples of products they would like to be able to prescribe including antibiotics, analgesics, treatment for diarrhoea, allergic rinitis and creams for the skin. Perhaps the NPF could be expanded on if more practitioners were to use their prescription pads in the first instance.

**BENEFITS AND BARRIERS**
There is evidence that nurse prescribing has led to improvements in patient-centred care, access to appropriate healthcare, patient safety and the reduction of GP appointments (RCN, 2012). These were the primary aims of nurse prescribing being established, along with reducing GP waiting lists and creating a flexible and responsive workforce (Bradley and Nolan, 2008).

Research has focused on identifying barriers to prescribing for health visitors, including:

- time to write prescriptions, especially in a busy clinic;
- lack of confidence;
- lack of time to document in clients’ and professional records;
- lack of advice and training;
- lack of support from other practitioners (While and Biggs, 2004).

More recently, Thurtle (2007) identified the absence of a ‘prescribing culture’ within health visiting, although there was optimism this could be a possibility. She conducted interviews with health visitors and their managers in one PCT and found there was a need for improved communication and structures to support the culture of prescribing, noting practitioners needed to be active in their own learning.

A recent project to address low prescribing activity provided clinical updates and reduced delays in receiving prescription pads for health visitors in an inner city location. This led to increased prescribing confidence and prescribing activity (Brooks, 2013).

**HOW TO GET AHEAD AS A STUDENT**
There are so many opportunities for you to observe and reflect on your role as a nurse prescriber. As a student you may find your practice teacher does not prescribe and you feel at a disadvantage over your colleagues. This should not deter you from your goal of successfully completing the V100 course to become a competent nurse prescriber.

Health visitors assess both mother and baby during each consultation, and you can highlight key experiences and log your prescribing hours through your attendance at child health clinics, and observing new birth and six-week contacts. You will be observing and then practising; first supervised and then unsupervised once you become competent in your practice.

You can start seeking out learning opportunities by arranging to observe other prescribers in the community setting, such as: pharmacists, GP consultations, family planning nurses, practice nurse prescribers, community nurses, district nurses, mental health practitioners, school nurses and specialist nurses, for example, consultations in allergy or enuresis clinics.

Become more familiar with your NPF and prescription pad; take out copies of a blank FP10 form to practise writing prescriptions during your day in practice. Talk to other nurse prescribers and observe others – even if they do not prescribe they are conducting consultations all the time and signposting clients to the appropriate agency for treatment, which is an integral part of the prescriber’s role.

**PRACTICAL ADVICE**
On qualifying, it is imperative you embrace and take responsibility for your own CPD. Maintaining competence is a requirement to remain registered as a prescriber. No one else can or will do it for you, so you can start by prioritising any opportunities for support, such as clinical supervision, preceptorship and attending prescribing updates or forums. You can keep yourself up-to-date with prescribing practice and knowledge through national and local guidelines, such as Meflec Briefings from the National Prescribing Centre (NPC). Use reflection to make action plans to identify further support or training. In reality this is not always easy; you will be presented with huge demands on your time and will often feel overwhelmed by the pressures of autonomous working and managing your time and diary. There will be a period of adjustment to your new role and this may even be in a new base, trust or team.

If you use these opportunities as a newly qualified health visitor, these practices will soon become engrained in your practice and time management skills. Research shows the designated leads for prescribing do not actually have stipulated time for this role (Courtenay et al, 2011) and this would explain the lack of structured support some health visitors are highlighting as a barrier.

**Keep the momentum going**
As a newly qualified health visitor and nurse prescriber your head will now be full of measurements, calculations, adverse drug reactions, contraindications, treatments and applications for a range of different conditions. This is in addition to knowledge of National Institute for Health and Care Excellence (NICE) guidelines, national and local policies and procedures, concordance, record-keeping and information governance. How do you now start to use your knowledge and gain
confidence to write your first prescription? If you do not keep the momentum going you are more likely to forget your newly acquired knowledge and put prescribing to the back of your mind.

**Identify your personal barriers to prescribing**

The products you are able to prescribe are limited and the more you practise the more familiar you will become with these products. I have found that clients do not mind waiting longer and I do not let this deter me from prescribing. If you deliver an effective consultation, which provides the patient with accurate, evidence-based and appropriate advice, you may or may not decide to prescribe at the end.

Writing a prescription only takes a minute – it is the consultation that is the crucial and lengthy process. During the consultation you must elicit the relevant information to make a clinical decision. Each consultation in clinic is important to each client, and they will come back to the clinic and wait again (or invite you back into their home) if you are able to develop a relationship based on trust and they feel they are being listened to.

**Discuss with colleagues and other medical and non-medical prescribers**

On qualifying, it is likely you will have to wait for your prescription pads before you can actually prescribe (David and Arena, 2000). It will be easy to put prescribing to the back of your mind while you become immersed in your practice at this time and I have observed this in my recent practice as a community practice teacher (CPT). However, you can use this interim time to make a start by meeting with GPs, the primary care team you are linked to and a local pharmacist. Make the most of primary care team meetings to discuss prescribing practices or set up one-to-one meetings. You can also have *ad hoc* discussions with health visitor or other nurse prescribing colleagues to explore their prescribing practices for different conditions, for example: management of oral candidiasis, eczema or head lice.

**Keep a reflective journal and reflect on your experiences**

Keep a journal to make notes for your prescribing. A student who is new to prescribing will often ask: ‘What do you prescribe for eczema?’ It is natural to search for the ‘correct’ answer. Remember every client, assessment and presentation of a condition is different. Through your module and in practice you will be encouraged to actively seek out the best evidence-based practice.

Follow the ‘seven principles of good prescribing’ (NPC, 1999) and, remember, the prescription is only one part of this process. Focus on the consultation itself. Continue to reflect over your experiences in practice, your assessments and the advice you give to clients.

It is important health visitors recognise how their prescribing skills impact on, and enhance, their practice. For example, you will meet clients and their families who have been diagnosed with medical conditions and are already having their care managed and medications reviewed by their GP or a consultant. This may be asthma, eczema, epilepsy, mental health conditions, diabetes, respiratory or cardiac conditions, among others. The community practitioner is in a position to offer opportunistic health promotion advice and education.

It is extremely common to find yourself discussing the use of prescribed paracetamol and over-the-counter medicines with clients. There will be opportunities to act as an advocate for your clients with mental health issues and it is not unusual to find yourself observing children’s inhaler techniques and discussing antibiotic use and misuse.

**MOVING FORWARD**

You should feel ready and able to start prescribing when you receive your prescription pad. Don’t delay, as you may then start to lose confidence in your abilities. If you keep sight of all the benefits to prescribing and the new knowledge you have gained, and take responsibility for your own professional development, this role can be incredibly rewarding and increase your job satisfaction. You will gain confidence as you continue your prescribing practice and you will, in turn, become a positive role model for your colleagues who are not using their prescribing privileges. If you start to create a prescribing culture in your team, others will follow your lead.

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Student Health Visiting: A Project to Foster Leadership

Claire Rickard, Student Health Visitor, Buckinghamshire New University

As a student on the specialist community public health nurse (SCPHN) health visitor BSc course at Buckinghamshire New University, one of the modules we are required to complete is a leadership and management module. As part of this, we were asked to organise a conference entitled ‘Celebrating Community Nurse Education’.

We were told we would be put into groups, each of which would be responsible for a specific area of organising the conference. As part of this, we would have to perform a Dragon’s Den-style pitch to bid for money for our group. The mixture of emotions passing across my colleagues’ faces ranged from horror, to excitement, to fear.

Our group was allocated the remit of marketing. We had to decide what we were going to pitch for and how we were going to perform our pitch. The lecturers had put the groups together and most were a mix of district nurses and health visitors. We did not know each other very well and we all felt out of our comfort zone. I understand now that the reason the lecturers did this was to show us that management will often make changes employees do not like or understand. It gave me a good insight into change management theories such as Lewin’s (1951).

All the groups experienced a degree of conflict. There were strong characters within the groups and I learned conflict often occurs within teams. As a group, we managed our conflict very well and made it through the forming, storming, norming and performing stages as Tuckman described (Tuckman and Jensen, 1977). By the time we reached the day of the pitch we were operating as a close-knit team.

One member of the group had designed an information leaflet, which outlined the types of community nursing courses that were available at the university.

The university marketing team printed the leaflets for us and another group member had telephoned companies asking for gifts that we could use as incentives. As a group, we received a lot of support from the university marketing and communications teams. We all met up on several occasions and they gave us access to banners and other marketing materials. The communications manager even offered to come and take photos on the day of the conference.
On the day of the pitch we were all very nervous. We knew that we would have to perform our pitch to five ‘Dragons’ and they would be performing a role. We knew the budget for the conference had already been set but we didn’t let that stop us from using our imagination and bidding for as much money as possible. The idea behind the pitch was to give us an insight into the process of commissioning services within the NHS, where specialist services – such as health visiting and district nursing – will be required to produce evidence of the quality of the services they provide and ‘sell’ these services to stakeholders such as the clinical commissioning groups and local authorities.

We entered the room and the five ‘Dragons’ introduced themselves and told us a little about their background. Three were our lecturers (who had adopted alter-egos for the purpose of the day!) and there were two guest ‘Dragons’. We had planned our pitch so that each group member would talk about different aspects of our marketing strategy and the money we needed to make our strategy a reality. We received really good feedback along with two offers of financial support and one of the ‘Dragons’ also offered us his marketing expertise. We left the room feeling very proud of ourselves and what we had achieved.

In the run up to the conference, the group who had been allocated the role of senior management team had the difficult task of trying to ensure everyone was kept informed of what each group was doing. This was made difficult by the fact that our time was split between college and work placement, and the academic deadlines that were fast approaching. We kept in touch via email and meetings in college when possible. I found this very similar to community working where people are often in and out of the office, juggling their caseloads, and it is often difficult to keep up-to-date with changes that are occurring.

When the day of the conference arrived, we pulled together as a cohort to ensure everything went as smoothly as possible. We had invited our community practice teachers, the January cohort of district nurses and health visitors and felt really proud of what we had managed to achieve and the delegates were very complimentary of the event as well. Crystal Oldman from the Queen’s Nursing Institute was our keynote speaker and it was inspiring to listen to her. Before she left, she approached a group of us and congratulated us on organising and hosting such a professional conference. I think that was a highlight of the day for me.

The whole process was a steep learning curve for me. When writing my leadership and management essay, I really felt my group had experienced many aspects of the theories I was reading about and members of my cohort said they felt the same. Domain D of the SCPHN standards of proficiency requires the facilitation of health activities through partnership working and leadership (Nursing and Midwifery Council, 2004). With the NHS reforms and the Francis report recommendations (2013), the need for improved training in leadership skills at all levels has been highlighted as a priority to improve patient safety.

As a result of the conference, I gained a real understanding of the process of group dynamics and the impact of change within these groups. We evolved from a group that had been forced together to a real team. I was surprised at how easily I adapted to change and the leadership qualities that emerged. I can now understand why the lecturers chose to give us the task of performing a pitch and organising a conference. It was an innovative way for our cohort to see leadership, management and collaborative working for ourselves.

I have just started my 10-week consolidation placement for my SCPHN training. One of the purposes of this placement is to develop my skills in leadership and management, and completing this module and organising and hosting a conference has taught me so many leadership and management skills. I have really enjoyed my SCPHN training so far, and even though it has been a tough year academically and I have had to juggle my personal life with completing the course full time, I have enjoyed feeling challenged and am looking forward to beginning my new career as a health visitor and making a real difference to children and their families.

REFERENCES


Thank you to all of you who submitted nominations and entries for the CPHVA Awards 2015 and the MacQueen Awards, which this year will be included in the Awards Ceremony on the 27th March.

The judging will take place throughout February, by our select panel of judges and

the shortlisted candidates will be announced soon, in forthcoming editions of Community Practitioner and on the Community Practitioner Website.

We look forward to celebrating your achievements with you on the 27th March, whether as an individual or part of a team.

www.communitypractitioner.com/awards
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Lactose is a sugar found in milk and dairy. A deficiency in the enzyme lactase stops the body breaking down the lactose sugar.1

Common symptoms

Undigested lactose remains in the intestine and can cause diarrhoea, abdominal distension, nausea, flatulence and bloating.1,2

Primary lactase deficiency

Lactase intolerance can affect any infant but primary lactase deficiency is genetic and more common in Hispanic, Asian and black populations, with around 20% of children under 5 affected.2

Secondary lactase deficiency

A common, but temporary, cause of diarrhoea, it often occurs because of damage to the intestinal brush border, where lactase production takes place. It is brought about by untreated coeliac disease, Crohn’s disease and severe gastroenteritis caused by infections, such as rotavirus.1,2

Although temporary, it may take weeks rather than days for lactase secretion to be adequately re-established. Formula fed infants may require a lactose free formula as a temporary substitute for standard cows’ milk formula.1

Studies have shown that infants with diarrhoea fed on lactose free formula milk recovered in significantly less time than those fed on a lactose containing formula.3,4

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Lactose free formula is well accepted and tolerated and maintained growth at a comparable level to that in infants receiving lactose containing formula.6

*IMPORTANT NOTICE: Breastfeeding is best for babies. Breast milk provides babies with the best source of nourishment. Infant formula milk and follow on milks are intended to be used when babies cannot be breast fed. The decision to discontinue breast feeding may be difficult to reverse and the introduction of partial bottle-feeding may reduce breast milk supply. The financial benefits of breast feeding should be considered before bottle feeding is initiated. Failure to follow preparation instructions carefully may be harmful to a babies health. Infant formula and follow up milks should be used only on the advice of a healthcare professional.

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*As of March 2014, as checked via company carelines

Assessment and management of feeding difficulties in infants

NIGEL MEADOWS MD FRCPCH
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Honorary Senior Lecturer, Queen Mary Westfield, London University

Feeding difficulties in infants present a common problem for all healthcare professionals. They result in significant anxiety for parents, who feel pressure to ensure their child eats a balanced diet and demonstrates appropriate weight gain. This pressure comes from many sources, including health professionals, relatives, the media and society as a whole. Studies have shown that as many as 30 per cent of children will develop some difficulty with eating. These problems can be varied and range from a child who is thought to be fussy or picky to the child who refuses food and is unable to take enough calories to thrive.

In clinical practice there are three broad groups of problems, although there is a lot of overlap. These include: an aversion to texture, where lumpy foods are rejected; an aversion to certain tastes where particular food types are refused; or in severe cases neophobia, where there is an inability to introduce any new foods into the diet.

In newborns, feeding difficulties present with refusal of milk and difficulty with sucking or swallowing, or discomfort during a feed. The peak age for feeding difficulties is at six months, when solid foods are introduced, although in many cases there have been subtle indicators previously. This is an important milestone in development as it represents the start of chewing.

As with other developmental milestones, it is well recognised that the stimulus ie, solid food, needs to be introduced at the correct time. If this is delayed the skill has to be learned, which makes the later development of managing solids difficult (Rommel et al, 2003; Miller-Lonner et al, 2004; Illingsworth and Lister, 1964).

There is no satisfactory definition of feeding difficulties and this can cause confusion as to which children need intervention and what services are required. There is no doubt that children who have faltering growth should be assessed and it is most effective when a multidisciplinary team achieves this. Parental anxiety and regular monitoring of weight gain in record books means that, usually, the first port of call is the health visitor. Currently, there is very little consensus as to the correct management for these children. This results in confusion among healthcare professionals, heightening parental anxiety and aggravating the difficulties.

At the multidisciplinary feeding clinic at the Royal London, it has become apparent that many feeding difficulties have an original insult, often medical, which has resulted in a maladaptation in feeding behaviour. The significance of this is that in severe feeding problems, the rigid separation between organic and non-organic approaches is doomed to failure. Feeding clinics are increasing in many health districts to provide support for this group. The key members of such a team are dietitians, speech and language therapists, and nurses. It is also helpful to include an interested paediatrician, at least in the initial assessment.

INFANTS AT RISK

Some groups of infants can be identified early. This enables professionals, particularly dietitians and speech and language therapists, to provide support and practical advice to parents. Studies of preterm babies have shown an increase in the development of feeding difficulties, such as uncoordinated sucking and swallowing. This appears to be separate from neurological problems. Many of these babies are tube-fed for a varying period. If no stimulus is provided to encourage sucking, a change to oral feeding may be difficult and longstanding. Neonatal intensive care units are now aware of this potential problem and are increasingly involving speech and language therapists early (Jonsson et al, 2013).

Children with a neurological handicap often present with slow, difficult feeding, which is often an early clue to the diagnosis. An early speech and language therapy review is essential to ensure that swallowing is safe, with no risk of aspiration. This group requires specific intervention by specialist teams and is not discussed further in this paper.

As we have already noted, a delay in providing a stimulus of chewing at the milestone of six months makes the later development of managing solids difficult. This was highlighted in 1987 in east London, where it was observed that it was a common practice to delay weaning foods and provide convenience sweet foods such as egg custard. These children had difficulty in establishing lumpy foods, even as toddlers.

Any child with a medical problem may have difficulty in sucking, for example: those with congenital heart disease who cannot provide the energy required in sucking.
The introduction of new foods is difficult and often very slow. It must be remembered that it takes over 20 times of exposure for a normal individual to decide they like it.

Children with congenital gastrointestinal problems, such as tracheo-oesophageal fistula, will inevitably have difficulty due to the dysmotility of the oesophagus, which persists even after surgical correction.

PRESENTATION OF FEEDING DIFFICULTIES

The most common presentation in babies is a refusal to suck or screaming and pulling away during feeds. This is commonly associated with arching of the back and stiffening. These symptoms are often related to gastro-oesophageal reflux, or milk allergy.

At the time of weaning, a common presentation is gagging on lumps. In many children this is normal and will improve, but if it persists it may develop into a refusal of any food other than almost a puree. This can often be misconstrued as vomiting. A specific preference for food types can develop as, if not corrected, psychology alone will not suffice.

Drooling is an important observation and, again, indicates an urgent speech and language therapist’s opinion, particularly if it is associated with recurrent chest infections. It is associated with neurological problems or involvement of the larynx such as a cleft.

A frequent sign, often ignored, is a delay in duration of meal times. Most children will take adequate calories over 30 minutes. Longer than this results in frustration in parent and child, and may lead to force feeding (Falconer, 2010).

ASSESSMENT

The first step in assessment is an accurate measurement of both height and weight, with a review of the health record to identify faltering growth. A detailed medical history is taken to identify potential risk factors and developmental progress. Physical examination will exclude associated medical problems. It should be noted that it is important to examine the mouth, which is often neglected. A sub-mucosal cleft of the palate is often missed. The jaw shape needs to be examined, as malformations such as Pierre Robin (an anomaly with typical features of small lower jaw, cleft palate and upper airway obstruction) will interfere with effective feeding.

A dietary history should be taken to demonstrate calorie intake. In babies, the type of milk should be noted. In children on a weaning diet, it is important to explore the potential of micronutrient deficiencies such as iron. A speech and language therapy review is needed to look for episodes of choking, respiratory infections. An observation of feeding will reveal disco-ordinate swallow, and potential for aspiration.

A psychosocial review is important to review the family dynamics around feeding, parental anxieties and expectations. The settings of a normal mealtime are helpful, particularly looking at issues such as force feeding. A review of the child’s behaviour in general is helpful and, although rare, it should be remembered that children on the autistic spectrum could present with feeding issues.

GASTRO-oesophageal reflux disease

In the author’s experience, gastro-oesophageal reflux disease (GORD) is the most common medical association with feeding difficulties. This often involves problems of both texture and taste. Reflux is almost universal in babies in the first six months of age. If there are problems such as pain, chest infections or discomfort, it is termed reflux disease or GORD. There may not be associated vomiting and in this situation it is referred to as ‘silent reflux’.

The discomfort experienced by the patient is related to food and an aversive pattern is established. It is important to consider this in children with feeding difficulties as, if not corrected, psychology alone will be unsuccessful. Food allergy is often an association and needs to be considered. There may not be a rash, but here is often a history of atopy in the family (Falconer, 2010).

MANAGEMENT

It must be stressed that a multidisciplinary approach is best. The association with antecedent organic problems needs to be identified and managed alongside the psychological approach to succeed. It should be recognised that babies very quickly learn to modify their behaviour in response to aversive episodes such as choking, pain and vomiting, particularly if they occur at the same time as feeding.

Routine medical screening tests are difficult to establish due to the varied conditions involved. Currently, tests for GORD are invasive, such as endoscopy and impedance, and are reserved only for those children with severe problems or failure to thrive.

Dietary management is aimed to provide adequate calories for growth and correction of vitamin or trace element deficiency. Supplemental feeds and advice about calorie-dense foods may be helpful to re-establish weight gain. The child with reflux and delayed emptying may be helped by small, frequent volumes. Fluid intake is important, as many of these children may have associated constipation.

Children at risk of aspiration require an assessment of eating with video-fluoroscopy. An experienced speech and language therapist must perform this. This can also be an adjunct to therapy, as the handling of both solids and liquids can be reviewed, and if liquids are aspirated, they may be tolerated if thickened.

Children, such as those with oesophageal dysmotility, are helped considerably by drinking fluid during a meal, as it seems to help food bolus to be cleared. Children who have an aversion to lumpy foods may be helped by the introduction of bite and dissolved foods, which are easier to clear the mouth, and may give the child some confidence to handle them.

The introduction of new foods is difficult and often very slow, to the frustration of carers. It must be remembered that it takes over 20 times of exposure for a normal individual to decide they like it. Therefore, parents need to have realistic expectations. To the child, there is a real fear associated with the new foods; the introduction with miniscule portions such as a pinhead may help.

GENERAL BEHAVIOURAL APPROACHES

The first step to any practical management is to address the anxiety of the parents.
It must be remembered that feeding is a dyad, and their attitudes and fears may have an additional aversive effect. The most common worry is inadequate weight gain. The child has been regularly weighed and monitored, and there is extreme pressure on the parents to achieve the desired weight. If this seems to be failing they resort to force feeding, which creates increasing fear for the child around meal times and worsens the situation.

Our policy is to explain to the parents that we will take responsibility for weight gain during the programme. It is often difficult to change entrenched behaviour and it is essential that all members of the family are consistent in their approach.

Realistic volumes of intake must be set for the child, taking note of problems such as delayed gastric emptying. The duration of eating is also important and a limit should be set. Meal times have often become a protracted battlefield for the whole family, which is counterproductive. If new foods are being tried it is often helpful to only set aside one meal for this.

Young children who are food aversive will often benefit from messy play with food, and getting used to food on their fingers. It is important that the child has some involvement and control over their feeding, and the use of finger foods may help them to get used to control of lumps, which in the face of oral aversion is less threatening than being spoon-fed. Many groups, such as Sure Start centres, now have regular sessions on this and often watching others is beneficial. In older children it should be borne in mind that the pressure for change is from the parent. If the child is putting on weight they often have no drive to change their eating pattern. Any interventions are almost impossible until the older child wants to change, and this often comes from peer pressure rather than parents.

Very rarely, in severe cases of failure to thrive, tube feeding may be needed. This is for as short a period as possible. During this period, oral feeding is still important. The advantage is that meal times are less pressured and one mealtime can be set aside for this (Lukens and Silverman, 2014).

**CONCLUSION**

Feeding difficulties are an important but poorly recognised problem in childhood. Management is often difficult because of the need for a multidisciplinary approach. Parents need a lot of support during a difficult time. Meals should be enjoyable, and it is hard for families when it is a constant battle.

Any management of this problem should take into account both the organic and non-organic aspects of the etiology. In most health areas, it is encouraging there are teams emerging with the required expertise to provide help.

**REFERENCES**


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**CPD questions (please visit www.communitypractitioner.com/CPD to submit your answers)**

<table>
<thead>
<tr>
<th>1. What percentage of children develop some difficulty with eating?</th>
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<tbody>
<tr>
<td><em>Mouth</em></td>
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<td><em>Legs</em></td>
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<td>10</td>
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<td>20</td>
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<td>30</td>
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<td>40</td>
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<td>7. How many times of exposure does it take for an individual to decide they like a food?</td>
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<td><em>20</em></td>
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<td>2. What is the peak age of feeding difficulties?</td>
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<td><em>3 months</em></td>
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<td><em>4 months</em></td>
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<td><em>5 months</em></td>
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<td><em>6 months</em></td>
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<tr>
<td>3. There is no satisfactory definition of feeding difficulties – true or false?</td>
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<tr>
<td><em>True</em></td>
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<tr>
<td><em>False</em></td>
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<td>4. How many minutes does it take for most children to take adequate calories?</td>
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<td><em>30</em></td>
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<td><em>40</em></td>
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<td><em>50</em></td>
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<td><em>60</em></td>
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<tr>
<td>5. Which of the following is most common in presentations of babies with feeding difficulties?</td>
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<tr>
<td><em>Drooling</em></td>
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<td><em>Screaming and pulling away during feeds</em></td>
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<td><em>Fever</em></td>
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<td><em>Bleeding gums</em></td>
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<td>6. During assessment it is important to examine which part of the body?</td>
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<tr>
<td><em>Eyes</em></td>
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<td><em>Arms</em></td>
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<td>8. At what age is it important to have introduced solid foods?</td>
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<td><em>4 months</em></td>
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<td><em>6 months</em></td>
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<td><em>1 year</em></td>
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<tr>
<td><em>2 years</em></td>
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<tr>
<td>9. There is often a history of atopy in the family of a child with gastro-oesophageal reflux disease – true or false?</td>
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<tr>
<td><em>True</em></td>
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<tr>
<td><em>False</em></td>
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<tr>
<td>10. The term ‘silent reflux’ refers to what?</td>
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<tr>
<td><em>Reflux with associated vomiting</em></td>
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<tr>
<td><em>Reflux without associated vomiting</em></td>
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<tr>
<td><em>Reflux with fever</em></td>
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<tr>
<td><em>Reflux with rash</em></td>
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- Child development – with Juliette Francis Tuesday 24th February at Hilton St Anne’s Manor, Wokingham at 6pm
  Register at www.hipp4hcps.co.uk
- An introduction to autism – with Lorraine MacAlister Wednesday 18th March online at 6pm
  Register at www.hipp4hcps.co.uk
- Feeding Infants – is less more? – with Professor Atul Singhal
  Tuesday 28th April at the Royal College of Surgeons of England, London at 6pm
  Register at www.hipp4hcps.co.uk
- Feeding Infants – is less more? – with Professor Atul Singhal
  Wednesday 13th May at the Solent hotel and spa, Fareham, Hampshire at 6pm
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